MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46)

CERTIFICATE OF DEATH

0C791

Reg. Dist. No. 231

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Prince George
City or town: Cheverly, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Prince George Hospital
How long in hospital or institution? 4 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Prince George
City or town: Cheverly
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1801-64th Ave Cheverly, Md.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: William ATwater

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	widower

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug. 15 - 1873

8. AGE: Years	Months	Days	If less than one day
72	7	12	..... hrs. ..... min.

9. Birthplace: New York (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business

FATHER
12. Name: Edw. ATwater
13. Birthplace: Providence, R.I.

MOTHER
14. Maiden name: Frances Longworth
15. Birthplace: New York.

16. Informant: Katherine ATwater
Address: 1801-64th Ave Cheverly, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 2, 1945 (month) (day) (year)
Cemetery or crematory: Evergreen
Location: Bladensburg Md
18. Funeral director: E Gaddis sons
Address: Hyattsville Md

19. Jan 30 1945 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 27 1945, at 5.50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 11 1945, to Jan 27 1945 and that I last saw h. LIM. alive on Jan 26 1945

Immediate cause of death	DURATION
Carcinoma of Transverse Colon.	3 yrs.
Due to	
Due to	
Other conditions: Cirrhosis-Gangrene of left foot (Include pregnancy within 3 months of death)	10 days

Major findings of operations: None Date of op.
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John D. Maloney, M.D. M. D. or other
Address: Cheverly-Hyattsville Md. Date signed 1-27-45

Evidence for change of age is shown on

FILM No. G95 JUN 5 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

00702 T

Reg. Dist. No. 242

1. PLACE OF DEATH:
County Prince George
City or town Forestville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince George
City or town Forestville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Norman Mackin Bailley

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife Marion Lisell
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) October 29-1905

8. AGE: Years	Months	Days	If less than one day
39 -38-	2	4	hrs. min.

9. Birthplace Philadelphia, Pa.
(Town, county, and state)
10. Usual occupation Postal Clerk
11. Industry or business Federal Govt.

FATHER
12. Name Phillip Bailley
13. Birthplace France

MOTHER
14. Maiden name Bertha Mackin
15. Birthplace Ireland

16. Informant Phillip Bailley
Address Forestville, Md.

17. Burial (Burial, cremation, or removal, which?) Date thereof Jan. 6-45 (month) (day) (year)
Cemetery or crematory Cedar Hill
Location Suitland, Md.

18. Funeral director Ritchie Brothers
Address Upper Marlboro, Md.

19. 1/5/45 (Date rec'd by registrar) 19 Thos. E. Griffith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 3 1945 at 5:22 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 27 1944, to Jan 3 1945
and that I last saw h.. alive on Dec 30 1944

Immediate cause of death	DURATION
(a) Tuberculosis	
Due to (b) Pulmonary tuberculosis	
Due to (c)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE James D. Boyd M. D. or other
Address Forestville Md. Date signed 1-5-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for change of cause of death is shown on FILM No G 94 APR 7 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

00703

Reg. Dist. No. 231

1. PLACE OF DEATH:
County Prince Georges
City or town Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 day
Hospital, institution, or street address where death occurred: Prince Georges Genral Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town Capital Heights
(If outside city or town limits, write RURAL and give nearest town)
Street No. 302 Prince Georges Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME William Ball

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept 6, 1901

8. AGE: Years 43 | Months 4 | Days 14 | If less than one day ..... hrs. ..... min.

9. Birthplace Washington D.C. (Town, county, and state)
10. Usual occupation Carpenters Helper
11. Industry or business Building

FATHER
12. Name Samuel Eugene Ball
13. Birthplace Maryland

MOTHER
14. Maiden name Ella Fowler
15. Birthplace Washington D.C.

16. Informant Mrs. Ella T. Ball
Address 411 - Hamilton St. NW

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 23 1945 (month) (day) (year)
Cemetery or crematory Ft. Lincoln
Location Bladensburg Md.
18. Funeral director Deal Funeral Home
Address 4812 Ga Ave N.W. Wash D.C.

19. Jan. 21 1945 (Date rec'd by registrar) Amanda Dauney Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 20 1945 at 6.04 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death ..... DURATION
Cerebral Compression .....
Due to Extra dural hemorrhage .....
Due to Laceration of Middle Meningeal Artery .....
Other conditions Fracture of skull .....
Due to Accidental Fall Cause of death
(Include pregnancy within 3 months of death)

Major findings of operations .....
..... Date of op. .....
Autopsy results Autopsied
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury Accidental Fall Injured at work? .....

23. SIGNATURE Thomas S. Leary Deputy Medical Examiner
M. D. or other
Address Forestville Md. Date signed 1-22-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

00704

CERTIFICATE OF DEATH

Reg. Dist. No. 23 2

1. PLACE OF DEATH:

County Prince Georges

City or town Suitland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2½ months

Hospital, Institution, or street address where death occurred:

4326 Alabama Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Suitland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4326 Alabama Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Milton Addeson Barham

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 4, 1940

8. AGE:

Years	Months	Days	If less than one day
4	8	7	hrs. min.

9. Birthplace Washington DC (Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER

12. Name Milton Addeson Barham

13. Birthplace Washington DC

MOTHER

14. Maiden name Florence Harrison

15. Birthplace Virginia

16. Informant Raymond W. Barham

Address 5613 Randolph Pl., Villa Heights

17. Removed (Burial, cremation, or removal, which?) Date thereof 1-15-45 (month) (day) (year)

Cemetery or crematory Arlington National

Location

18. Funeral director W. W. Chamberlain

Address 517-11th St. S.E.

19. Jan 12 1945 (Date rec'd by registrar) R. Earl Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 11 1945, at 4:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19, to 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Shock	
Due to Unexplained burns	
Due to The body	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 1-11-45

Where did injury occur? Suitland Pr. Geo. Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury House burned down Injured at work? No

Deputy medical examiner

23. SIGNATURE James E. Bond M. D. or other

Address Forestville Md. Date signed 1-12-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

STATE OF MARYLAND—CERTIFICATE OF DEATH 00705

1. PLACE OF DEATH (08)

County Prince George Registration Dist. No. 231

Village or City Prince George Hospital No. St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

2. FULL NAME William Bartley If U. S. Veteran, specify WAR

(a) Residence: No. 2nd St Laurel Md St., Ward.
(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male.	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, and year) Oct 1872

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
72	3		

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. Laborer

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Maryland

FATHER

13. NAME George Bartley

14. BIRTHPLACE (city or town) (State or country) Maryland

MOTHER

15. MAIDEN NAME Elizabeth Gibson

16. BIRTHPLACE (city or town) (State or country) Maryland

17. INFORMANT Mrs. Thomas J. Thompson
(Address) 4th St Laurel Md.

18. BURIAL, CREMATION, OR REMOVAL
Place Ivy Hill Date Jan. 26, 1945

19. UNDERTAKER Ridgely Selby
(Address) 401 Second Ave. Laurel Md

20. FILED Jan. 26, 1945 Mrs. Jas. Devereux
Deputy Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Jan (Month) 24th (Day) 1945 (Year)

22. I HEREBY CERTIFY, That I attended deceased from 1 19, 1945, to 1 2, 1945

I last saw h[illegible] elive on 1 2, 1945; deeth is said to have occurred on the date stated above, at m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of oneet
Lobar Pneumonia	1 19 45
Other Contributory Causes of importance:	
Acute Cardiac Dilatation	

Name of operation Date of

Whet test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur?
(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) B Patterson M. D.

(Address) Laurel Md

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as **at school** or **at home**. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and **own home** in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel,** etc. For a person who had no occupation whatever write **none.**

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver,** etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill,** etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer,** etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist,** etc. Distinguish carefully between **retail merchants** and **wholesale merchants.** A person who sells goods should be called a **salesman** and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, **not** the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00706

CERTIFICATE OF DEATH

Reg. Dist. No. 232

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

1. PLACE OF DEATH:
County Prince Georges
City or town Meadows
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Prince Geo.
City or town
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Richard Melvin Batson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Colored	Single

6.(b) Name of husband or wife —

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Aug. 8 1944

8. AGE: Years | Months 4 | Days | If less than one day ____ hrs. ____ min.

9. Birthplace Prince Georges County (Town, county, and state) Maryland

10. Usual occupation none

11. Industry or business

FATHER
12. Name James B. Batson
13. Birthplace Md.

MOTHER
14. Maiden name Mary Ford
15. Birthplace Md.

16. Informant Mary Batson
Address Meadows Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 4 1945 (month) (day) (year)
Cemetery or crematory St Lukes
Location Meadows Md

18. Funeral director J. B. Johnson
Address Annapolis

19. Jan 2 1945 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 2 1945 at 7 45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1945 to Jan 2 1945 and that I last saw him alive on Jan 1 1945

Immediate cause of death	DURATION
Bronchopneumonia	6 days
Due to —	
Due to —	
Other conditions — Unknown	

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op.

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE [signature] M. D. or other

Address Washington 19 DC Date signed 1/2/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (124-2)

CERTIFICATE OF DEATH

00707

Reg. Diat. No. 243

1. PLACE OF DEATH:

County PRINCE GEORGE'S

City or town BOWIE, MARYLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 YEARS

Hospital, institution, or street address where death occurred:

AT HOME

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George

City or town Bowie

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME JACOB GUY BELL

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	White	MARRIED

B.(b) Name of ~~husband~~ or wife ANN AUGUSTA BELL

8.(c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) JANUARY 16, 1880

8. AGE: Years	Months	Days	If less than one day
64	11	~~29~~ 28	....hrs. ....min.

9. Birthplace ODENTON, MARYLAND (Town, county, and state)

10. Usual occupation INVESTIGATOR

11. Industry or business

FATHER — 12. Name HENRY BELL

13. Birthplace ODENTON, MARYLAND

MOTHER — 14. Maiden name ADDIE WAITS

15. Birthplace ODENTON, MARYLAND

16. Informant MRS. J. GUY BELL

Address BOWIE, MARYLAND

17. Burial (Burial, cremation, or removal. Which?) Date thereof JAN 18 1945 (month) (day) (year)

Cemetery or crematory Fort Lincoln

Location Colmar Manor Md

18. Funeral director E. Gaeckle sons

Address Hyattsville Md

19. Jan 17 1945 (Date rec'd by registrar) Mrs. J. W. Yeingling Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JANUARY 14 1945 at 4:50 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 8 1944, to Jan. 14 1945

and that I last saw h... alive on Jan. 14 1945

Immediate cause of death	DURATION
Uremia Coma	2 days.
Due to Carcinoma of Liver	5 months
Due to Cardio-Renal Disease	6 months
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Harry S. Clemens Jr. M.D.

M. D. or other

Address Bowie, Md Date signed 1-17-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (164-C)

CERTIFICATE OF DEATH

0078

Reg. Dist. No. 232

1. PLACE OF DEATH:
County: Prince Georges
City or town: Seat Pleasant
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 years
Hospital, institution, or street address where death occurred:
9 Ring Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Seat Pleasant
(If outside city or town limits, write RURAL and give nearest town)
Street No. 9 Ring Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: John Alfred Belt

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Grace M Belt
6.(c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): March 1, 1882

8. AGE:

Years	Months	Days	If less than one day
62	10	30	hrs. min.

9. Birthplace: Coalesville, Md
(Town, county, and state)
10. Usual occupation: Government Worker
11. Industry or business: Fn-S. Port.

FATHER
12. Name:
13. Birthplace: Unknown

MOTHER
14. Maiden name:
15. Birthplace:

16. Informant: Bertha B. Grimes
Address: Ring Street, Seat Pleasant
17. Removal (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)
Cemetery or crematory: W W Chambers
Location: 517-11 Washington D C
18. Funeral director: W. W. Chambers
Address: 517-11 St S.E. Washington D C
19. Feb 1st 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 31 1945, at 5:00 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Hemorrhage and shock	
Due to: Gun shot Wound of Head	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide? Suicide Date of 1-31-45
Where did injury occur? Seat Pleasant P G Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Home
Means of injury: Gun-shot Injured at work? No

23. SIGNATURE: Preliminary medical Examination
M. D. or other
Address: Forestville Md Date signed: 1-31-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

60709

Reg. Diat. No. 245

1. PLACE OF DEATH:

County: Prince George's

City or town: Hyattsville, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 54 years

Hospital, institution, or street address where death occurred: 5502 43rd Place

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Prince George's

City or town: Hyattsville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5502 43rd Place

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Nannie Berry Benton

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Widow

6.(b) Name of husband or wife: William H. Benton

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): September 20, 1861

8. AGE: Years	Months	Days	If less than one day
83	3	30	....hrs. ....min.

9. Birthplace: Clark County, Va (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: at home

FATHER — 12. Name: George W. Gordon

FATHER — 13. Birthplace: Va

MOTHER — 14. Maiden name: Lydia M. Cain

MOTHER — 15. Birthplace: Va

16. Informant: Iris N. Brooks

Address: Hyattsville, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof JAN 22 1945 (month) (day) (year)

Cemetery or crematory: Glenwood

Location: Washington Ave

18. Funeral director: E. Gaeth's sons

Address: Hyattsville Md

19. Jan. 20 1945 (Date rec'd by registrar) Mrs. Jas. Severe, Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 19 1945 at 6 10 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 25 1944, to January 19 1945

and that I last saw h.. alive on January 19 1945

Immediate cause of death	DURATION
Chronic Hypertension	6 mos
Due to: Senility	Several years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.: —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: W. Allen Griffith M. D. or other

Address: Berwyn, Md Date signed 1/19/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

0710

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:
County: Prince Georges County
City or town: Riverdale Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 months
Hospital, Institution, or street address where death occurred:
Bennett Houses, Rest Home
How long in hospital or institution? 4 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Silver Spring Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 9614 Bristal Ave.,
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mr Theodore Peter Biallas

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Nina christine Biallas
6.(c) If alive, give age: 44 years

7. Birth date of deceased (mo., day, yr.): June 19, 1889

8. AGE: Years	Months	Days	If less than one day
55	6	13	...hrs. ...min.

9. Birthplace: St. Louis, Missouri (Town, county, and state)
10. Usual occupation: Architect
11. Industry or business: Associate naval architect
FATHER 12. Name: H Peter Biallas
13. Birthplace: Germany
MOTHER 14. Maiden name: Anna Tockrucke
15. Birthplace: Missouri
16. Informant: Leland Hospital Riverdale Md
Address: Mrs. Riverdale, Md
17. Removal (Burial, cremation, or removal. Which?) Date thereof: Jan 11-1945 (month) (day) (year)
Cemetery or crematory:
Location: 641-H St NE Wash D.C.
18. Funeral director: Albert Jacobs
Address: 641-H St NE Wash D.C.
19. Jan. 11" 1945 Mrs. Jas. Sevens (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 11 1945, at 4 15 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 11 1944, to Jan 11 1945 and that I last saw h.. alive on Jan 11 1945

Immediate cause of death	DURATION
Cerebral Thrombosis	1 yr.
Due to: General arterio sclerosis	9 yrs.
and Hypertension	
Due to:	
Other conditions: R/T Bronchopneumonia	1 yr.

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

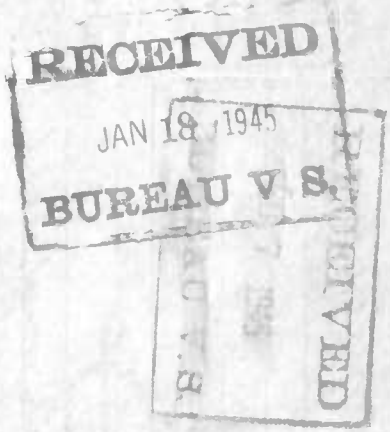
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ...Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: ...Injured at work?

23. SIGNATURE: L W Milian M.D.
M. D. or other
Address: Riverdale, Md Date signed: 1-11-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15


RECEIVED
JAN 18 1945
BUREAU V S.

0711

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

Reg. Dist. No. 2-26

1. PLACE OF DEATH:
County: Prince Georges
City or town: Berwyn 1st 8603 60th Ave
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 years
Hospital, institution, or street address where death occurred:
8603 - 60th - Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Prince Geo.
City or town: 8603 - 60th Ave
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Berwyn Md
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Earnest Arwood Blair

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Emily Porter Blair
6.(c) If alive, give age: 58 years

7. Birth date of deceased (mo., day, yr.): June 30 - 1880

8. AGE: Years	Months	Days	If less than one day
64	6	3	hrs. min.

9. Birthplace: New Brunswick Canada (Town, county, and state)
10. Usual occupation: Printer
11. Industry or business: Gov. Printing Office
FATHER 12. Name: Wm. Burtt.
FATHER 13. Birthplace: Unknown
MOTHER 14. Maiden name: Miss. Louisa Burtt.
MOTHER 15. Birthplace: New Brunswick Canada.
16. Informant: Emily Porter Blair
Address: 8603 - 60th Ave
17. Transportation (Burial, cremation, or removal. Which?) Date thereof Jan 9. 1945 (month) (day) (year)
Cemetery or crematory: Bybee
Location: Palmyra Va.
16. Funeral director: L Gaschs Sons
Address: Hyattsville Md.
19. Jan 8th 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION 45

20. DATE OF DEATH: Jan 6, 1945, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 18 1944, to January 6 1945
and that I last saw him alive on January 2 1945

Immediate cause of death	DURATION
Apoplexy	2 days
Due to: Chronic Hypertension	Several years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. Allen Griffith M. D. or other
Address: Berwyn Md Date signed 1/8/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-C)

00712

CERTIFICATE OF DEATH

Reg. Diat. No. 245

1. PLACE OF DEATH:

County Prince Georges

City or town Hyattsville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Hyattsville (If outside city or town limits, write RURAL and give nearest town)

Street No. 5705 Baltimore ave (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Loula Loula Hanguen Blake

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife William P. Blake

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 3, 1860

8. AGE: Years 84 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Singers Glen Va. (Town, county, and state)

10. Usual occupation At Home

11. Industry or business

FATHER 12. Name J. B. Hanguen

13. Birthplace Virginia

MOTHER 14. Maiden name Mary E. Funk

15. Birthplace Virginia

16. Informant Nelson M. Blake

Address 5705 Baltimore ave Hyattsville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 11 1945 (month) (day) (year)

Cemetery or crematory Fort Lincoln

Location

18. Funeral director A. H. Hines Co

Address 2901 - 14 st. N.W.

19. Jan 8 1945 (Date rec'd by registrar) Jas Berne Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 8 1945 at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 1 1944 to Jan 8 1945

and that I last saw her alive on Jan 1 1945

Immediate cause of death Pyloric Obstruction Carcinoma of Pylorus

Due to and Cachexia

Due to

Other conditions

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. Scott Bell M. D. or other

Address Hyattsville Md. Date signed 1-8-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 48a

CERTIFICATE OF DEATH

00713

Reg. Diat. No. 245

1. PLACE OF DEATH:
County: Prince George County
City or town: Riverdale, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 41 days
Hospital, institution, or street address where death occurred:
Eugene Leland Memorial Hospital
How long in hospital or institution? 41 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George
City or town: College Park, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 7011 Wakefarest Drive
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Blanchard, Mrs. Kathryn theresa

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

6.(b) Name of husband or ~~wife~~: Mr. Oscar Knowles Blanchard
6.(c) If alive, give age: 39 years
7. Birth date of deceased (mo., day, yr.): March 13, 1906

8. AGE: Years	Months	Days	If less than one day
38	10	16	..... hrs. ..... min.

9. Birthplace: Pa. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: William James Wilson
13. Birthplace: Pa.

MOTHER
14. Maiden name: Ida marie Colin
15. Birthplace: Pa.

16. Informant: O. Knowles Blanchard
Address: 7011 Wake Forest Drive College Park Md
17. Cremation (Burial, cremation, or removal. Which?) Date thereof 1-30-45 (month) (day) (year)
Cemetery or crematory: Ft. Lincoln Cemetery
Location: Mount ~~P.O.~~ Colmar Manor Md.
18. Funeral director: W. D. Chambers
Address: Riverdale Md.
19. Jan 29 1945 Mrs. Jas. Devere Deputy Local Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 29, 1945 at 12:50 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 5 1944 to Jan 29 1945
and that I last saw h~~e~~r alive on Jan 29 1945

Immediate cause of death	DURATION
Carcinoma of Cervix with Metastases to bladder	3 yrs
Due to: and Rectum with abscess	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: Same as cause of death
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: L W Malin M.D. M. D. or other
Address: Riverdale Md. Date signed 1-29-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

00714

Reg. Dist. No. 230

1. PLACE OF DEATH:
County: Prince Geo Co. Md.
City or town: Berwyn
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 years
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Pre Geo Co
City or town: Berwyn Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 8405 48 ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mrs Annie May Boteler

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widower

6.(b) Name of husband or wife: Joseph J. Boteler
7. Birth date of deceased (mo., day, yr.): March 10th 1865
6.(c) If alive, give age: 80 years

8. AGE: Years: 80 Months: — Days: — If less than one day: hrs. min.

9. Birthplace: Washington D.C. (Town, county, and state)
10. Usual occupation: At home
11. Industry or business:

FATHER
12. Name: John T. Soare
13. Birthplace: Md

MOTHER
14. Maiden name: Annie May Soare
15. Birthplace: D.C.

16. Informant: John T. Boteler
Address: 9620 Baltimore Berwyn Md

17. (Burial, cremation, or removal. Which?) Burial Date thereof: Jan 9 1945 (month) (day) (year)
Cemetery or crematory: St John Episcopal Cemetery
Location: Beltsville md
16. Funeral director: E Sandia Soare
Address: Hyattsville md

19. (Date rec'd by registrar) January 9th 1945 Johan D Sasatte Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 6 1945 at 2.40 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from November 16 1942 to Dec 6 1944
and that I last saw h[illegible] alive on Dec 5 1944

Immediate cause of death	DURATION
Hypertensive heart disease	3 years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C Reetz M.D.
Address: Hyattsville Md M. D. or other
Date signed: 1-8-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Evidence for change of cause of death is shown on FILM No. G 94 APR 7 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (17)

CERTIFICATE OF DEATH

00715

Reg. Diat. No. 24

1. PLACE OF DEATH:
County: Prince George
City or town: Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 years.
Hospital, institution, or street address where death occurred: Prince George Gen. Hosp.
How long in hospital or institution? 10 Hours.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Prince George.
City or town: Laurel
(If outside city or town limits, write RURAL and give nearest town)
Street No. 114 Washington Blvd.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Patrick Harry Bowers.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
m	w	single

6.(b) Name of husband or wife: Bachelor

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.) 9/25/54 (automobile license) Howe

8. AGE: Years	Months	Days	If less than one day
90 90	3	16	hrs. min.

9. Birthplace: Penn. (Town, county, and state)
10. Usual occupation: Retired Foreman
11. Industry or business:
12. FATHER — Name: Unk.
13. FATHER — Birthplace:
14. MOTHER — Maiden name:
15. MOTHER — Birthplace:
16. Informant: Mr. Cordell Thrift. Address: Laurel
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 22/1945 (month) (day), (year)
Cemetery or crematory: Immanuel Meml. Pk.
Location: Mt. Rainier, Md.
18. Funeral director: Mt. Rainier Funeral Home Inc.
Address: Mt. Rainier, Md.
19. Jan 17 1945 (Date rec'd by registrar) Mrs. J. W. Yingling Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 10 1945, at 1:27 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 9 1945, to Jan 10 1945
and that I last saw h[illegible] alive on Jan 9 1945

Immediate cause of death	DURATION
Uremia - Poisoning.	
Due to eating Meat - ptomaine	
Duration - one week.	
Due to Spoilt meat.	
Other conditions Chronic Myocarditis	
Interstitial Nephritis	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or Coroner
Address: Laurel, Md. Date signed: Jan 17 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

00716

CERTIFICATE OF DEATH

Reg. Dist. No. 27 242

1. PLACE OF DEATH:

County: Pr. George's

City or town: Fairmont Heights
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? residence

Hospital, institution, or street address where death occurred:
****

How long in hospital or institution? ***

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Pr. Geo.

City or town: Fairmont Heights.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 602 59th Avenue, N.E.
(If rural, give LOCATION)

2.(a) If veteran, name war: ****

3.(a) FULL NAME: Francis J. Cardozo

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	Col..	Married

6.(b) Name of husband or wife: Helen Cardozo

6.(c) If alive, give age: 65(?) years

7. Birth date of deceased (mo., day, yr.): September 19 1865

8. AGE: Years	Months	Days	If less than one day
79	4		....hrs. ....min.

9. Birthplace: Charleston, S.C.
(Town, county, and state)

10. Usual occupation: Teacher (Retired)

11. Industry or business: Public Schools

FATHER
12. Name: ***?***
13. Birthplace: S.C.

MOTHER
14. Maiden name: ***?***
15. Birthplace: ***?***

16. Informant: Mrs. Addie L. Cardozo
Address: 654 Girard Street, N.W., Wash., D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1. 29. 45 (month) (day) (year)

Cemetery or crematory: Woodlawn Cemetery
Location: Washington D.C.

18. Funeral director: Edwin L. Williams
Address: 1810 - 9th St. N.W.

19. Jan 25 1945 (Date rec'd by registrar) Margaret Brunette D.R. -Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 24 1945 at 6 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1944 to Jan 24 1945 and that I last saw h... alive on Jan 24 1945

Immediate cause of death	DURATION
Hypertensive Heart Disease	7
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ....Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): .....

Means of injury: Injured at work?

23. SIGNATURE: Edwin L. Williams, M. D. or other

Address: 4629 Deane Ave. N.E. Date signed: 1/24/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-A)

00717

CERTIFICATE OF DEATH

Reg. Diat. No. 234

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Prince Georges
City or town: Accokeek
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Accokeek
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Francis Melvin Carroll

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Laura Carroll
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct 31, 1870

8. AGE:	Years	Months	Days	If less than one day
	74	2	14	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business

FATHER 12. Name	George Washington Carroll
FATHER 13. Birthplace	Maryland
MOTHER 14. Maiden name	Catherine Alice Elizabeth
MOTHER 15. Birthplace	Maryland

16. Informant: Catherine Blandford
Address: Accokeek, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-15-45 (month) (day) (year)
Cemetery or crematory: St Mary
Location: Piscataway Md
18. Funeral director: Smith & Ryan
Address: Mallow Md
19. Jan. 16 1945 (Date rec'd by registrar) Mrs Alton Davis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 12 1945 at 8:00 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute Congestive heart failure	
Due to Cerebrovascular renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Deputy Medical Examiner
M. D. or other
Address: Aquasco Md Date signed 1-17-45

DATE:::Letter filmed G98 10-8-45 from Dr. Griffith. L.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

00718

Reg. Diat. No. 245

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Pr. Geo

City or town: Leland Mem Hospt

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Riverdale Md

Hospital, institution, or street address where death occurred: 6 months

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: College Park

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 4710 Calvert Rd

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Jennie E. Clark

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widow

8.(b) Name of husband or wife:

8.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov 1, 185[illegible]

8. AGE: Years	Months	Days	If less than one day
89			hrs. min.

9. Birthplace: Mt Vernon Ohio (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: James W. Miller

13. Birthplace: Vermont

MOTHER — 14. Maiden name: Mary E. Bryant

15. Birthplace: Ohio

16. Informant: Miss Helen S. Clark

Address: College Park Md

17. Burial. (Burial, cremation, or removal. Which?) Date thereof: Jan 31, 1945 (month) (day) (year)

Cemetery or crematory: National Capital Cemetery

Location: Muirkirk Md.

18. Funeral director: F Gaeke sons

Address: Hyattsville Md.

19. Jan 30 45 (Date rec'd by registrar) Mrs. Jan Lovere Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 28 19 45 at 10 45 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 29 19 44, to January 28 19 45

and that I last saw h[illegible] alive on January 28 19 45

Immediate cause of death	DURATION
Chronic Hypertension	Several years
Due to Arterio Sclerosis	Several years
Due to Senility	Several years
Other conditions Fractured femur about two years ago	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE: W Allen Griffith M. D. or other

Address: Berwyn Md Date signed: 1/28/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00719

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince George's

City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mos., 18 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 2 mos., 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County: Washington

City or town:
(If outside city or town limits, write RURAL and give nearest town)

Street No. 36 Daggs Place S. E.
(If rural, give LOCATION)

2.(a) If veteran, name war: –

3.(a) FULL NAME: JOHN W. COATES

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife: –

6.(c) If alive, give age: ... years

7. Birth date of deceased (mo., day, yr.): November 26, 1888

8. AGE: Years	Months	Days	If less than one day
56	1	25	...hrs. ...min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business: –

FATHER
12. Name: Henry Coats
13. Birthplace: Maryland

MOTHER
14. Maiden name: Lottie Beverly
15. Birthplace: Washington, D. C.

16. Informant: Decedent.
Address

17. Removal to (Burial, cremation, or removal. Which?) Date thereof: Jan 21, 1945 (month) (day) (year)

Cemetery or crematory:

Location: Washington D.C.

18. Funeral director: Ralph H Bell

Address: 1023 Bellt. St. S.E.

19. Jan 20, 1945 (If not rec'd by registrar) Rowland Phillips Dep Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 20, 1945, at 4.50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 2, 1944, to Jan 20 1945 and that I last saw him alive on Jan 19, 1945

Immediate cause of death: Pulmonary Tuberculosis — DURATION: 9 mo.

Due to: ...

Due to: ...

Other conditions: ...
(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: Daniel Lea Pinucane M.D. M. D. or other

Address: Glenn Dale, Md. Date signed 1/20/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-d

00720

CERTIFICATE OF DEATH

Reg. Dist. No. 245

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Pr. Geo
City or town Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State md County Pr. Geo
City or town Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4003 Queensbury Rd
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME William S. Grimm

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	widowed

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 21-1863

8. AGE: Years	Months	Days	If less than one day
82			..... hrs. ..... min.

9. Birthplace Mannington W. Va. (Town, county, and state)

10. Usual occupation Retired Painter

11. Industry or business

FATHER 12. Name Feilding Crim
13. Birthplace Usa

MOTHER 14. Maiden name Daisy Norton
15. Birthplace Usa

16. Informant Mrs Jennie Hunter
Address 4003 Queensbury Rd Hyattsville

17. a Fighting (Burial, cremation, or removal. Which?) Date thereof 1-20-45 (month) (day) (year)

Cemetery or crematory Mannington
Location Mannington W. Va.

16. Funeral director W W Chambers & Son
Address Riverdale md.

19. Jan 19 1945 (Date rec'd by registrar) James Berry Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 18 1945 at 11:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 8 1945 to Jan 18 1945
and that I last saw h alive on Jan 16/45 1945

Immediate cause of death	DURATION
Cardiac failure	2 da's.
Due to Senile T & Myocardial ty	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Joseph D Barden M. D.
M. D. or other

Address 4316 Gallatin St. Date signed Jan 19/45
Hyattsville, Md

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

00721

CERTIFICATE OF DEATH

Reg. Diat. No. 230

1. PLACE OF DEATH:

County: Penna Georges

City or town: Greenbelt

(If ontside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

4 J Ridge Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Penn Georges

City or town: Greenbelt

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 4 J Ridge Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Robert Andrew Curry Jr

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): March 23, 1943

8. AGE: Years: 1 | Months: 9 | Days: 15 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Charleroi Pa

(Town, county, and state)

10. Usual occupation: —

11. Industry or business:

FATHER — 12. Name: Robert Andrew Curry

13. Birthplace: Fayette City, Pa

MOTHER — 14. Maiden name: Pauline A Smallwood

15. Birthplace: Pennsylvania

16. Informant: Mrs R A Curry

Address: Greenbelt, Pa

17. Transportation (Burial, cremation, or removal. Which?) Date thereof: Jan 10, 1944 (month) (day) (year)

Cemetery or crematory:

Location: Connellsville, Penna

18. Funeral director: L Gaschi Sons

Address: Hyattsville, Md

19. Jan 9th 1944 (Date rec'd by registrar) John D Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 9 1945 at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Tapeworm	
Due to: Bronchopneumonia	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Deputy Medical Examiner

James D Beard M.D. or other

Address: Forestville Md Date signed: 1-9-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

00722

Reg. Diat. No. 245

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Prince Georges

City or town: Hyattsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs.

Hospital, institution, or street address where death occurred: Sacred Heart Home

How long in hospital or institution? 4 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1600 - 38th st. N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: CATHERINE DALY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Edward Daly

6.(c) If give, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1863

8. AGE: Years: 82 | Months: | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: D. C.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER — 12. Name: [illegible] Dennis Conner

13. Birthplace: Ireland

MOTHER — 14. Maiden name: Ellen Costello

15. Birthplace: Ireland

16. Informant: Joseph J. McCarthy

Address: 1606 - 38th N. W.

17. Removal (Burial, cremation, or removal. Which?) Date thereof Jan. 25 1945 (month) (day) (year)

Cemetery or crematory: Mt. Olivet Cemetery

Location: Washington D. C.

18. Funeral director: P. F. Castello

Address: 1722 North Capitol St.

19. Jan. 25 1945 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 25 1945, at 8:45 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1 1944, to Jan 25 1945 and that I last saw h[illegible] alive on Jan 25 1945

Immediate cause of death	DURATION
Heart failure	3 days
Due to: Coronary arteriosclerosis	1 year
Due to: General arteriosclerosis	1 year
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Joseph J. McCarthy M. D. or other

Address: 301 Transit Bldg. Date signed: 1/25/45

Evidence for change and addition on certificate is shown on 2411 N. Charles St., Baltimore (14a)

MARYLAND STATE DEPARTMENT OF HEALTH

00723

FILM No. G 9 4 MAY 4 1945

CERTIFICATE OF DEATH

Reg. Diat. No. 231

1. PLACE OF DEATH:

County: Prince Geo. County

City or town: Cheverly md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 days

Hospital, Institution, or street address where death occurred: Prince Geo. County

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Prince Geo. Co.

City or town: 4907 Ravenswood Riverdale Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Susanna May Hibbert Davidson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: Alfred Harvey Davidson

6.(c) If alive, give age: 76 years

7. Birth date of deceased (mo., day, yr.): March 28, 1870

8. AGE:

Years	Months	Days	If less than one day
74 yrs.	10	19	hrs. min.

9. Birthplace: ~~Del.~~ Wilmington, Delaware (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name: Hibbert, John Rathold

13. Birthplace: England

MOTHER 14. Maiden name: Susanna Dickinson

15. Birthplace: Pa.

18. Informant: Alberta Dula (Daughter)

Address 4907 Ravenswood, Riverdale, md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof Jan. 19, 1945 (month) (day) (year)

Cemetery or crematory: Wash. D.C.

Location

18. Funeral director: Martin W. Hysong Co.

Address 1300 - N. st. N W Wash D.C.

19. Jan. 19 1945 (Date rec'd by registrar) Amanda Denney Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 19 1945 at 12.55 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 2 1945, to Jan 19 1945 and that I last saw h.. alive on Jan 18 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	
due to Arteriosclerosis	3 Years
Due to	
Other conditions Myocarditis & Nephritis	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John W. Mahoney M. D. or other

Address Cheverly-Hyattsville Date signed 1-19-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-A)

00724

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:
County Prince George
City or town Chapel Oaks
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 months
Hospital, Institution, or street address where death occurred:
5414 - Nash Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince George
City or town Chapel Oaks
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5414 - Nash Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME William Andrew Hansey

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

8.(b) Name of husband or wife Narcessius D. Hansey
8.(c) If alive, give age 32 years
7. Birth date of deceased (mo., day, yr.) March 10, 1891

8. AGE:

Years	Months	Days	If less than one day
53	9	26	..... hrs. ..... min.

9. Birthplace Burgess' Store Va (Town, county, and state)
10. Usual occupation Laborer
11. Industry or business Truck

FATHER
12. Name William Hansey
13. Birthplace Virginia

MOTHER
14. Maiden name Hannah Williams
15. Birthplace Virginia

16. Informant Narcessius D. Hansey
Address 5414 - Nash Street, Chapel Oaks

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 10, 1945 (month) (day) (year)
Cemetery or crematory Folly
Location Va.
18. Funeral director Carthon L. Rollins
Address 4339 - Hunt Pl. NE.

19. January 6 1945 Irene G. Combs
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 6 1945 at 6.45 P.M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from ..... 18..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
(a) Acute Congestive heart failure	
Due to (b) Cardio Vascular	
Due to (c) Renal disease	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation .....
..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

Deputy Medical Examiner
23. SIGNATURE James J. Ford M. D. or other
Address Forestville Md. Date signed 1-6-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(1) MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (BL)

CERTIFICATE OF DEATH

00725

Reg. Diat. No. 243.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Prince George's
City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 3611 Wisconsin Ave. N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: JAMES A. DOVE

3.(b) Social Security Number: 578-18-1299

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: –
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 23, 1901

8. AGE: Years	Months	Days	If less than one day
43	6	16	hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)
10. Usual occupation: Electric Work
11. Industry or business:

FATHER
12. Name: James Alfred Dove
13. Birthplace: Maryland

MOTHER
14. Maiden name: Margaret A. Burch
15. Birthplace: Maryland

16. Informant: Decedent
Address:

17. Removal to (Burial, cremation, or removal. Which?) Date thereof: Jan 10, 1945 (month) (day) (year)
Cemetery or crematory:
Location: Washington, D. C.

18. Funeral director: Jos. F. Birch's Sons
Address: 3034-M Street N.W. - Wash., D.C.

19. Jan 9 1945 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 9 1945 at 3:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 29 1944, to Jan. 9, 1945
and that I last saw h. alive on Jan. 9, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	6 mo
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Lee Pincane M.D.
M. D. or other
Address: Glenn Dale, Md. Date signed: 1/9/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-C)

CERTIFICATE OF DEATH

00726

Reg. Diat. No. 245

1. PLACE OF DEATH:

County Prince Georges

City or town Riverdale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 weeks

Hospital, Institution, or street address where death occurred:

Leland Memorial Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town College Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. Cool Spring Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME William Fairfax Cleve

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	married

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) dec 12, 1866

8. AGE:

Years	Months	Days	If less than one day
78	4	29	..... hrs. ..... min.

9. Birthplace Fairfax Va.

(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER

12. Name William F Cleve

13. Birthplace Unknown

MOTHER

14. Maiden name Mary Jane Harris

15. Birthplace Virginia

16. Informant Mary Jane Cleve

Address College Park, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 13 1945 (month) (day) (year)

Cemetery or crematory St. Johns

Location Beltsville Md

18. Funeral director F Casalis Sons

Address Hyattsville Md

19. Jan. 13 1945 Mrs. Jas Devers Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 11 1945, at 5:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death Respiratory paralysis	
Due to Ascending paralysis due to Ascending Myelitis	
Due to Traumatic Myelitis	
Other conditions Acute hemorrhagic pneumonia	
Toxic myocarditis	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results no alone

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 12-5-44

Where did injury occur? College Park Pr. Geo Md

(City or town) (County) (State)

Injured at home, farm, industry, public place (where) Route #1

Means of injury Pedestrian struck by car Injured at work? no

Deputy medical Examiner

23. SIGNATURE ..... M.D. or other

Address Hyattsville Md Date signed 1-12-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for the change of sex is shown on G101 4/17/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-P)

00727

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:
County: Pr Georges
City or town: Maryland - Riverdale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Dec. 21, 1944 - Jan 28, 1945
Hospital, institution, or street address where death occurred: Leland Memorial Convalescent Home
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R F D
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Evans, Richard

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	Widowed

6.(b) Name of husband or wife: Leanah Evans
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 11 - 1869

8. AGE:	Years	Months	Days	If less than one day
	76			hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business
FATHER — 12. Name: unknown
13. Birthplace: "
MOTHER — 14. Maiden name: unknown
15. Birthplace: "
16. Informant: Mrs Bessie Lucas
Address: 3453 Eads St N.E.
17. Burial, cremation, or removal. Which?: Removal — Date thereof: 1-30-45 (month) (day) (year)
Cemetery or crematory:
Location: 3072 - M. St. N.W. Wash D.C.
18. Funeral director: L.W. Chambers Co
Address: Riverdale, Md.
19. Date rec'd by registrar: January 29, 1945 — Mrs. Jas. Devere, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 28 1945, at 10 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 21 1944 to Jan 28 1945 and that I last saw h— alive on Jan 28 1945

	DURATION
Immediate cause of death: Cerebral Thrombosis	3 Mo.
Due to: General Arteriosclerosis	10 years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: L.W. Malin M.D. M. D. or other
Address: Riverdale, Md Date signed: 1-28-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00728

CERTIFICATE OF DEATH

Reg. Diat. No. 2475

1. PLACE OF DEATH:
County: PRINCE GEORGES
City or town: HYATTSVILLE (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 MONTHS
Hospital, institution, or street address where death occurred: SACRED HEART HOME
How long in hospital or institution? 7 MONTHS

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: D. C County:
City or town: WASHINGTON (If outside city or town limits, write RURAL and give nearest town)
Street No. 26 GRANT CIRCLE N. W (If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: ELLA E. FLYNN

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	SINGLE

6.(b) Name of husband or wife:
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): SEPT. 23, 1876

8. AGE: Years: 68 | Months: | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: MARYLAND (Town, county, and state)
10. Usual occupation: RETIRED
11. Industry or business: HOUSEKEEPER
FATHER 12. Name: JAMES A. FLYNN
13. Birthplace: IRELAND
MOTHER 14. Maiden name: MARY E. DRENNAN
15. Birthplace: MARYLAND
16. Informant: SACRED HEART HOME RECORDS
Address: HYATTSVILLE, MD
17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 1-12-45 (month) (day) (year)
Cemetery or crematory: ST. MICHAELS CEMETERY
Location: CLEAR SPRINGS, MD.
18. Funeral director: Francis Hallin
Address: 3821-14th. St. NW. Wash. D.C.
19. Jan 11" 1945 Mrs. Jas. Devere (Deputy) Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 10 19 45, at 1:15 M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 19 45, to Jan 10 19 45
and that I last saw h.er alive on Jan 9 19 45

Immediate cause of death	DURATION
Carcinoma of Stomach	Five years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Thomas Hallin M. D. or other
Address: 332 H ST NE Date signed 1-10-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

00729

Reg. Dist. No. 233

1. PLACE OF DEATH:
County: Pr. Geo's Co
City or town: Baden
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 mos.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Pr. Geo's Co
City or town: Baden
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Dorothy Elizabeth Ford

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col	single

6.(b) Name of husband or wife: -

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 5 - 44

8. AGE: Years: | Months: 8 | Days: 17 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Baden Pr. Geo's Co Md
(Town, county, and state)

10. Usual occupation: -

11. Industry or business: -

FATHER
12. Name: George A Ford
13. Birthplace: Brandywine Md

MOTHER
14. Maiden name: Mary Rose Lyons
15. Birthplace: Aquasco Md.

16. Informant: Geo. A. Ford

Address: Aquasco Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 21 1945 (month) (day) (year)

Cemetery or crematory: St. Peters Cemetery

Location: Wallows Md

18. Funeral director: Hunter & Regan

Address: Waldorf Md

19. 1-22-1945 (Date rec'd by registrar) M. L. Morris Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 20 1945, at 2 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 19 - 1945, to Jan 20 1945 and that I last saw h.e alive on Jan 19 - 1945

Immediate cause of death	DURATION
Broncho Pneumonia	
Due to	
Due to	
Other conditions: Premature Child	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W M Bowen
M. D. or other

Address: Aquasco Md. Date signed 1-20-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (105)

00730

CERTIFICATE OF DEATH

Reg. Dist. No. 842

1. PLACE OF DEATH:

County: Prince Georges

City or town: Seat Pleasant

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years.

Hospital, Institution, or street address where death occurred: 415-69th Place

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Seat Pleasant

(If outside city or town limits, write RURAL and give nearest town)

Street No. 415-69th Place

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Gloria Jean Gardiner

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): September 15, 1941

8. AGE: Years: 3 | Months: - | Days: | If less than one day: ____ hrs. ____ min.

9. Birthplace: Seat Pleasant (Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER — 12. Name: Dwyane Eugene Gardiner

FATHER — 13. Birthplace: Equasco, Md.

MOTHER — 14. Maiden name: Margaret Elizabeth Redding

MOTHER — 15. Birthplace: Seat Pleasant, Md.

16. Informant: Mrs. Margaret Gardiner

Address: 415-69th Place, Seat Pleasant Md.

17. Burial, cremation, or removal. Which?: Burial — Date thereof: Jan 13/45 (month) (day) (year)

Cemetery or crematory: Lake Hill Memorial Park

Location: Lodge Maryland

18. Funeral director: L. H. Blanchard Co

Address: 317 11th St. S.E.

19. Jan. 11 1945 (Date rec'd by registrar) Irene A. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 10 1945 at 11:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 10 1945, to January 10 1945 and that I last saw h— alive on January 10 1945

Immediate cause of death	DURATION
Congenital birth edema + anoxemia	8 hours
Due to:	
Due to:	
Other conditions: Cretinism	3 years

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op.: ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: ____ Date of: ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?): ____

Means of injury: ____ Injured at work?

23. SIGNATURE: William Brannin M. D. ~~or other~~

Address: 612 4 Central Ave, Capitol Hgts, Md. Date signed: 1/10/45

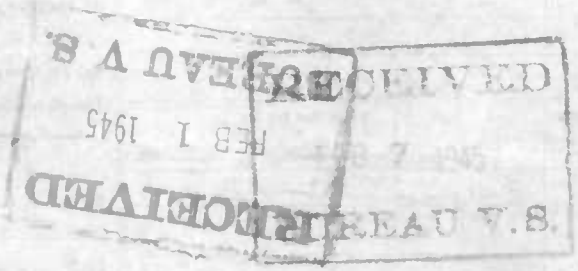
(over)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1/10/45 Coroner, J.J. Boyd notified + NK given
W Branning, MD



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (117)

CERTIFICATE OF DEATH

00731

Reg. Dist. No. 231

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Prince Geo.

City or town: Cheverly Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 days

Hospital, institution, or street address where death occurred:
Prince George Hospital

How long in hospital or institution? 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Prince Geo.

City or town: College Park
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4302 Knox. Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME

Gilbert Mrs. Augusta Edel

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 1, 1876

8. AGE: Years	Months	Days	If less than one day
69	8	28	hrs. min.

9. Birthplace: Bavaria
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: Geo. Edel
13. Birthplace: Bavaria

MOTHER
14. Maiden name: Amelie Monica
15. Birthplace: Haag, Urban

16. Informant:
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 31. 1945 (month) (day) (year)

Cemetery or crematory: St Johns
Location: Bettsville Md

16. Funeral director: F Raschs sons
Address: Hyattsville Md

19. Jan. 30 1945 (Date rec'd by registrar) Amanda Dawney Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1-29-45 19 , at 3:40 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 1) 19 45, to 1-29 19 45

and that I last saw her alive on 19

Immediate cause of death	DURATION
Gangrene Drug	2 days
Due to Intestinal vomiting	
Due to Gastric retention + Intestinal obstruction.	10 days
Other conditions Ruptured duodenal ulcer 1 mo. + retroduodenal abscess	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: same.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: A Heath MD M. D. or other

Address: Hyattsville Md Date signed: 1-29-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00732

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince George's
City or town: (rural) Glenn Dale, Maryland
(If ontside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 mos., 21 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 1 mo., 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1717 Seaton St. N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: JAMES LESLIE GOLDEN.

3. (b) Social Security Number: 572-12-8309

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widowed

6.(b) Name of husband or wife: Lucy Golden (dec.)
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): January 1, 1892

8. AGE: Years	Months	Days	If less than one day
53	-	18	..... hrs. ..... min.

9. Birthplace: Standardsville, Virginia (Town, county, and state)
10. Usual occupation: Houseman- Wardman Park Hotel
11. Industry or business:

FATHER
12. Name: James Golden, Sr.
13. Birthplace: Standardsville, Virginia

MOTHER
14. Maiden name: Lucy Holmes
15. Birthplace: Standardsville, Virginia

16. Informant: Decedent
Address:

17. (Burial, cremation, or removal. Which?) Removal to Date thereof Jan. 22, 1945 (month) (day) (year)
Cemetery or crematory:
Location: Washington, D.C.
18. Funeral director: L. C. Jennings - Sr
Address: 1337-10 St N.W.

19. (Date rec'd by registrar) Jan. 19, 1945 Rowland A. Phillips Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 19 th 1945 at 8 10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 29 th 1944 to January 19 th 1945 and that I last saw him alive on January 19 th 1945

Immediate cause of death	DURATION
Carcinoma of Stomach	3 mo
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operation: Autopsy Carcinoma of stomach - with local metastases to liver + glands. Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other
Address: Glenn Dale, Md. Date signed: 1/19/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

00733

CERTIFICATE OF DEATH

Reg. Diat. No. 243

1. PLACE OF DEATH:
County: Prince George's
City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 mos., 12 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 2 mos., 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 5232 Sherrier Place N. W.
(If rural, give LOCATION)
2.(n) If veteran, name war: V

3.(a) FULL NAME: GEORGE GRAVES

3.(b) Social Security Number: 579-16-7080

4. Sex	5. Color or race	6.(n) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Julia Graves
6.(c) If alive, give age: 44 years

7. Birth date of deceased (mo., day, yr.): October 26, 1900

8. AGE: Years	Months	Days	If less than one day
44	2	25	hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)
10. Usual occupation: Shoe Clerk
11. Industry or business:
FATHER 12. Name: George Graves
13. Birthplace: Washington, D. C.
MOTHER 14. Maiden name: Fannie Hainnie
15. Birthplace: Philadelphia, Pennsylvania
16. Informant: Decedent
Address:
17. (Burial, cremation, or removal. Which?) Removal to Date thereof: Jan 21 1945 (month) (day) (year)
Cemetery or crematory:
Location: Washington, D. C.
16. Funeral director: W. W. Chambers Co.
Address: 3072 - M. St. N. W.
19. (Date rec'd by Registrar) Jan. 20 1945 Rowland L. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 20 1945, at 1:40 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 8th 1944, to Jan 20 1945
and that I last saw h. him alive on Jan. 20 1945

Immediate cause of death	DURATION
Pulmonary tuberculosis	11 mo.
Due to	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other
Address: Glenn Dale, Md. Date signed: 1/20/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 115-2

00734

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:
County: Prince George
City or town: Mornings Side Village
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Geo.
City or town: Mornings Side Village
(If outside city or town limits, write RURAL and give nearest town)
Street No. 201 Maple Road
(If rural, give LOCATION)
2.(a) If veteran, name war: none

3. (a) FULL NAME: PATRICIA ANNE HALL

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 20th 1938

8. AGE: Years: 6 Months: Days: If less than one day: hrs. min.

9. Birthplace: Washington DC
(Town, county, and state)

10. Usual occupation: none

11. Industry or business: none

FATHER
12. Name: Robert H. Hall
13. Birthplace: Va

MOTHER
14. Maiden name: Clara N. Harper
15. Birthplace: Wash. D.C.

16. Informant: Mr Robert H. Hall
Address: 201 Maple Rd. Mornings Side, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 1-10-45 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: Suitland Md.

18. Funeral director: W. W. Chandler Co.
Address: 517 11th St S.E.

19. 1-8-45 (Date rec'd by registrar) Irene A. Bonnee Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January - 7 1945 at 11:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 27 1944 to January 7 1945 and that I last saw h alive on January - 7 1945

Immediate cause of death: Bronchitis of the pneumococcus - Staph. - Coccus Mixed Infection

Due to: Tonsillar infection

Due to: Long Standing

Other conditions: None

DURATION

(Include pregnancy within 3 months of death)

Major findings of operations: None

January - 7 Date of op. None

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Bernard L. French M. D. or other

Address: 1726 - M St. N.W. Date signed: 1-7-45

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

00735

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince George's

City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr., 4 mos., 7 days

Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 1 yr., 4 mos., 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 114 - 13th St. N. E.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: EMMA P. HEALD.

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

B.(b) Name of husband or wife: –

B.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 11, 1862

8. AGE: Years	Months	Days	If less than one day
82	8	28	hrs. min.

9. Birthplace: Sebec, Maine
(Town, county, and state)

10. Usual occupation: Retired Government Clerk

11. Industry or business:

FATHER — 12. Name: Azel Heald

13. Birthplace: Madison, Maine

MOTHER — 14. Maiden name: Pauline Tinkham

15. Birthplace: Anson, Maine

16. Informant: Decedent

Address:

17. (Burial, cremation, or removal. Which?) Removal to Date thereof (month) Jan. (day) 11 (year) 1945

Cemetery or crematory:

Location: Washington, D.C.

18. Funeral director: John Lee Sons Co.

Address: 300 4½ St NE.

19. (Date rec'd by registrar) Jan. 9 1945 Rowland S. Phelps Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 9th 1945 at 7 15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 2nd 1943, to January 9th 1945 and that I last saw her alive on January 9th 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	2 yr. 5 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Lee Duncan M.D. M. D. or other

Address: Glenn Dale, Md. Date signed: 1/9/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157)

00736

CERTIFICATE OF DEATH

Reg. Dist. No. 245

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Prince George

City or town Riverdale, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 29 hrs.

Hospital, Institution, or street address where death occurred:
England Leland Memorial Hosp.

How long in hospital or institution? 29 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Prince George

City or town Riverdale
(If outside city or town limits, write RURAL and give nearest town)

Street No. 6216 57th Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Zonie Elizabeth Hess

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

1-29-45 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years	Months	Days	If less than one day
		1 day 5 hrs.	hrs. min.

9. Birthplace Riverdale, Prince George, Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name Theodore Ralph Hess
13. Birthplace Riverdale, Md.

MOTHER
14. Maiden name Laura Rebecca Gough
15. Birthplace Noblesville, Virginia

16. Informant Mother
Address 6216 57th Ave., Riverdale, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 1, 1945 (month) (day) (year)

Cemetery or crematory Evergreen

Location Bladensburg Md.

18. Funeral director J. Gaeth & Sons

Address Hyattsville Md.

19. Jan 30 1945 (Date rec'd by registrar) Mrs. Jas. Severe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-30- 1945, at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 29 1945, to Jan 30 1945 and that I last saw her alive on Jan 30 1945

Immediate cause of death	DURATION
Prematurity	1 day
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. C. Malin M.D.
M. D. or other

Address Riverdale, Md. Date signed 1-30-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13a)

00737

CERTIFICATE OF DEATH

Reg. Diat. No. 242

1. PLACE OF DEATH:
County Maryland (PG)
City or town Forestville, Md.
(If ontside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town Forestville, Md/
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war 1st World's War

3.(a) FULL NAME John Hill

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife Mary Gantt Hill
6.(c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) Dec. 23, 1882

8. AGE: Years	Months	Days	If less than one day
62			....hrs. ....min.

9. Birthplace Mount Airy, North Carolina (Town, county, and state)
10. Usual occupation Minister
11. Industry or business

FATHER
12. Name Allen Hill
13. Birthplace Mount Airy, North Carolina

MOTHER
14. Maiden name Fannie Raleigh
15. Birthplace Mount Airy, North Carolina

16. Informant Mary Gantt Hill
Address Forestville, Md.

17. Burial Date thereof Jan 5/1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Arlington Nat'l
Location Arlington, Va.
18. Funeral director John T. Stewart
Address 30 H St. NE. Wash, DC

19 Jan. 3 1945 Carrie Campbell
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 3 1945 at 12 15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1 1944, to Jan 3 1945 and that I last saw h[illegible] alive on Jan 2 1945

Immediate cause of death Acute myocardial decompensation — DURATION 1 day

Due to Cardiac Vascular Renal Disease — DURATION unknown

Due to Generalized Arteriosclerosis — DURATION unknown

Other conditions — DURATION

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE [illegible] M. D. or Coroner
Address Washington 19 DC Date signed Jan 3 1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for change of cause of death is shown on FILM No. G 9 4 MAY 16 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18-a)

CERTIFICATE OF DEATH

00738

Reg. Dist. No. 245

1. PLACE OF DEATH:
County: Prince Georges
City or town: Riverdale Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 months
Hospital, institution, or street address where death occurred:
Eugene Leland Memorial Hospital
How long in hospital or institution? 8 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County: —
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 3413-13th St Washington, D.C.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Mrs Mary Gertrude Hogan

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: John Hogan
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): March 27, 1872

8. AGE: Years	Months	Days	If less than one day
72	9		..... hrs. ..... min.

6. Birthplace: Washington D.C.
(Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER
12. Name: John George Schuly
13. Birthplace: Europe

MOTHER
14. Maiden name: Dorothea Zwenig
15. Birthplace: Europe

16. Informant: Hospital records
Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof 1-11-1945 (month) (day) (year)
Cemetery or crematory: 3605-14 St. N.W.
Location: Washington D.C.
18. Funeral director: F Gueverd Sons Co
Address: Washington D.C.

19. Jan 11 1945 (Date rec'd by registrar) Mrs Lue Lavere Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1-11- 1945 at 3:00 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 12 1944, to Jan 11, 1945 and that I last saw her alive on Jan 11, 1945

Immediate cause of death	DURATION
Fracture right hip	15 mo.
Due to: Accidental fall. cause	
Due to:	
Other conditions: General Arteriosclerosis	10 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of Accident 1943
Where did injury occur? Mt. Rainier (City or town) Prince George's (County) Maryland (State)
Injured at home, farm, industry, public place (where?): at home
Means of injury: Accidental fall. Injured at work?

23. SIGNATURE: L.O. Mulvin M.D.
M. D. or other
Address: Riverdale, Md. Date signed 1-11-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

STATE OF MARYLAND—CERTIFICATE OF DEATH

0739

(82)

1. PLACE OF DEATH — Social Security No. 577-01-3021

County Prince Geo. — Registration Dist. No. 26

Village or City Mt Rainier — No. 4108 30 St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where daath occurred 33 yrs. mos. ds. — How long in U. S. If of foreign birth? 59 yrs. mos. ds.

2. FULL NAME Gilbert W Hughes — If U. S. Veteran, specify WAR

(a) Residence: No. 4108 30 St., Ward. (Usual place of abode) — If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	white	married

5a. If married, widowad, or divorced HUSBAND of (or) WIFE of Kate B (Brereton) Hughes

6. DATE OF BIRTH (month, day, and year) April 21-1873

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	8	28	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Engineer

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. C & P Tel Co

10. Date dacaased last workad at this occupation (month and year) 1938 — 11. Total tima (yaars) spent in this occupation 35 y.

12. BIRTHPLACE (city or town) Canada (State or country)

FATHER

13. NAME Lait Knox

14. BIRTHPLACE (city or town) ~~Broadwal Ontario~~ (State or country) Wales Lait Knox

MOTHER

15. MAIDEN NAME Lait Knox

16. BIRTHPLACE (city or town) Lait Knox (State or country) Wales

17. INFORMANT Mrs. Kate B. Hughes (wife) (Address) 4108 30 Mt Rainier Md

18. BURIAL, ~~CREMATION, OR REMOVAL~~ National Capital Memorial Park; Jan 22. 1945

19. UNDERTAKER Warner E. Pumphrey (Address) Silver Spring, Md

20. FILED Jan 21, 1945 James Devery Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Jan (Month) 19 (Day), 1945 (Year)

22. I HEREBY CERTIFY, That I attended deceased from Jan, 1940, to Jan 19, 1945

I last saw h alive on Jan 18, 1945; death is said to have occurred on tha date stated above, at 7.30 A.m.

The PRINCIPAL CAUSE OF DEATH and ralated causes of importance were as follows:

	Date of onset
Arteriosclerotic Retinal sclerosis	1940
Immediate terminal cause Myocardial insufficiency (2 years)	1940
Other Contributory Causes of Importance:	

Name of operation — Date of

What test confirmed diagnosis? — Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also tha following:

Accident, suicide, or homicide? — Date of Injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, In HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, spacify

(Signed) Thos Parran M. D.

(Address) 4108 Jefferson St. Hyattsville Md

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I		Example II	
The principal cause of death and related causes of importance were as follows:	Date of onset	The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*	*Attack of epilepsy*	*1 week ago*
Chronic interstitial nephritis	*1921*	*Run over by street car*	*1 week ago*
Cerebral hemorrhage	*July 5, 1927*	*Peritonitis*	*3 days ago*
Other contributory causes of importance:		Other contributory causes of importance:	
Gallstones	*May 1, 1923*	*Gastroenteritis*	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00749

Reg. Dist. No. 100

1. PLACE OF DEATH:

County Prince Georges

City or town Clinton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month

Hospital, institution, or street address where death occurred:

Piscataway Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Clinton

(If outside city or town limits, write RURAL and give nearest town)

Street No. Piscataway Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Maxwell Sammoh Jackson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 4, 1944

8. AGE: Years | Months 1 | Days 18 | If less than one day hrs. min.

9. Birthplace Drury, Maryland

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Marshall A. Jackson

13. Birthplace Maryland

MOTHER 14. Maiden name Katie Amelia Johnson

15. Birthplace Maryland

16. Informant Mrs. Katie Jackson

Address Box 234 A Clinton Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-23-45 (month) (day) (year)

Cemetery or crematory Newtown

Location La Plata Md

18. Funeral director Marshall A. Jackson (Father)

Address Clinton, Md

19. 1-23 (Date rec'd by registrar) 19 45 Julia H. Pasey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 22 19 45 at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Tetanus	
Due to Bronchopneumonia	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Deputy Medical Examiner

M. D. or other

Address Forestville, Md Date signed 1-22-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (180)

CERTIFICATE OF DEATH

00741

Reg. Dist. No. 23-2

1. PLACE OF DEATH:

County: Prince Georges

City or town: Friendly

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: 7971 - Allentown Rd

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince George

City or town: Friendly

(If outside city or town limits, write RURAL and give nearest town)

Street No. 7971 - Allentown Rd

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Audrey Elaine King

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Dec. 13, 1940

8. AGE:

Years	Months	Days	If less than one day
4	0	27	hrs. min.

9. Birthplace: Silesia Md

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name: George Leonard King

13. Birthplace: Baldorf, Md

MOTHER 14. Maiden name: Leona Mae Cassell

15. Birthplace: Maryland

16. Informant: George L. King

Address: 7971 Allentown Rd

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-18-45. (month) (day) (year)

Cemetery or crematory: Oakland

Location: Waldorf, Md.

18. Funeral director: Pilkerton Brothers

Address: White Marsh, Md.

19. Jan 17 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 16 1945; about 10:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Shock	
Due to: Suffocation by fire	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 1-16-45

Where did injury occur? Friendly (City or town) Prince Georges (County) Md (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury: Burned Injured at work? No

23. SIGNATURE: [illegible] M. D. or other

Deputy medical Examiner

Address: Forestville Md Date signed 1-16-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Evidence for change of age of deceased is shown on FILM No. G 92 MAR 10 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

00742

Reg. Dist. No. 232

1. PLACE OF DEATH:
County Prince Georges
City or town Friendly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 7971 - Allentown Rd
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town Friendly
(If outside city or town limits, write RURAL and give nearest town)
Street No. 7971 - Allentown Rd
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Frances Loretta King

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 28, 1942

8. AGE: Years	Months	Days	If less than one day
2 +	10	16	hrs. min.

9. Birthplace Fort Washington Md (Town, county, and state)
10. Usual occupation
11. Industry or business
FATHER 12. Name George Leonard King
13. Birthplace Waldorf Md
MOTHER 14. Maiden name Leona Mary Cassidy
15. Birthplace Maryland
16. Informant George L. King
Address 7971 - Allentown Rd
17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-18-45 (month) (day) (year)
Cemetery or crematory Oakland
Location Waldorf, Md.
18. Funeral director P. Blue Bros.
Address Upper Marlboro, Md.
19. Jan 17 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 6 1945 at 10:00 A M
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Shock	
Due to Suppressed burns of the back	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 1-16-45
Where did injury occur? Friendly Pr. Geo. Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Home
Means of injury House burned down Injured at work? No

23. SIGNATURE Deputy Medical Examiner
M. D. or other
Address Forestville, Md. Date signed 1-16-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

00743

Reg. Dist. No. 282

1. PLACE OF DEATH:
County Prince Georges
City or town Friendly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
7971- Allentown Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town Friendly
(If outside city or town limits, write RURAL and give nearest town)
Street No. 7971- Allentown Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Howard Leonard King

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb 28, 1944

8. AGE: Years | Months 10 | Days 16 | If less than one day ..... hrs. ..... min.

9. Birthplace Fort Washington Md
(Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER
12. Name George Leonard King
13. Birthplace Waldorf Md

MOTHER
14. Maiden name Leona Mary Cassidy
15. Birthplace Maryland

16. Informant George L. King
Address 7971- Allentown Rd

17. Burial
(Burial, cremation, or removal? Which?) Date thereof 1-18-45
(month) (day) (year)
Cemetery or crematory Oakland
Location Waldorf, Md

18. Funeral director Pilchuk Brothers
Address Upper Marlboro, Md.

19. Jan 17 1945 R. Earl Lyon
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 16 1945, at 10:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death Shock	
Due to Impressed burns	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide accident Date of 1-16-45
Where did injury occur? Friendly (City or town) P.G. (County) Md (State)
Injured at home, farm, industry, public place (where?) Home
Means of injury Home burned Injured at work? No

23. SIGNATURE Helpity medical Examiner
M. D. or other
Address Friendly Md Date signed 1-16-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00744

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Rural — Glenn Dale, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 months - 14 days

Hospital, institution, or street address where death occurred: Glenn Dale Sanatorium

How long in hospital or institution? 8 mo's, 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D. C. County: —

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1033 - 30th, N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war: no V

3.(a) FULL NAME: JAMES, A WEE,

3.(b) Social Security Number: 578-20-4632

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	divorced

6.(b) Name of husband or wife: Ruby Gary

6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): December 25, 1903

8. AGE:

Years	Months	Days	If less than one day
41	—	24	..... hrs. ..... min.

9. Birthplace: St. Petersburg, Florida (Town, county, and state)

10. Usual occupation: cook

11. Industry or business: —

FATHER — 12. Name: Cary Lee

13. Birthplace: St. Petersburg, Florida

MOTHER — 14. Maiden name: Addie Dudley

15. Birthplace: same

16. Informant: deceased

Address

17. Removal to (Burial, cremation, or removal. Which?) Date thereof: Jan 19 1945 (month) (day) (year)

Cemetery or crematory

Location: Washington, D.C.

18. Funeral director: W Smith

Address: 1125-19 St. N.W.

19. Jan. 18, 1945 (Date rec'd by registrar) Rowland L Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 18th 1945, at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 6th 1944, to January 18th 1945 and that I last saw him alive on January 18th 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	11 months 9 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Daniel Leo Pinucane M.D. (M. D. or other)

Address: Glenn Dale, Md Date signed: 1/18/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93a)

00745

CERTIFICATE OF DEATH

Reg. Dist. No. 239

WITHIN CORPORATE LIMITS OF

1. PLACE OF DEATH:
County Prince George's Co.
City or town Laurel Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 yrs. 6 months
Hospital, institution, or street address where death occurred:
321 - Compton Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town Laurel
(If outside city or town limits, write RURAL and give nearest town)
Street No. 321 - Compton Ave.,
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Arthur Marr LeMerle

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife Elizabeth Goode LeMerle
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 16th 1866

8. AGE:

Years	Months	Days	If less than one day
78	5	20	hrs. min.

9. Birthplace Washington D.C.
(Town, county, and state)
10. Usual occupation Printer - Retired
11. Industry or business U.S. Govt. Printing Office
FATHER 12. Name Agustus L. LeMerle
13. Birthplace Washington, D.C.
MOTHER 14. Maiden name Eita Marr
15. Birthplace Washington D.C.
16. Informant Francis G. LeMerle
Address 321 - Compton Ave, Laurel Md.
17. Dry Hill Burial Date thereof 1 - 6 - 45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Dry Hill
Location Laurel Md
18. Funeral director L. G. Gorman & Son
Address Laurel Md
19. Jan 6 1945 M. Basheare
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 4th 1945 at 8:35 P M
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 3 1945, to Jan 4 1945
and that I last saw h[illegible] alive on Jan 4 1945

Immediate cause of death	DURATION
Acute myocarditis (93a)	1 wk
Due to	
Due to	
Other conditions	

(Incinde pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Robert S McKinney M.D.
M. D. or other
Address Laurel Md Date signed 1/6/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00746

Reg. Diat. No. 245

1. PLACE OF DEATH:
County Prince George
City or town Mt. Rainier
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince George
City or town Mt. Rainier
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3810-31
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME George H. Lilley

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of ~~husband~~ or wife Dora E. Lilley
6.(c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) Jan. 19th 1873

8. AGE: Years	Months	Days	If less than one day
71			hrs. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual occupation Retired
11. Industry or business

FATHER
12. Name Ambrose Lilley
13. Birthplace Md.

MOTHER
14. Maiden name Mary Wells
15. Birthplace Md.

16. Informant Mrs. Dora E. Lilley
Address 3810-31 St. Mt. Rainier Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 8th 1945 (month) (day) (year)
Cemetery or crematory Ivy Hill
Location Laurel Md.

18. Funeral director William J. Dalley
Address 3200-R.I. Ave. Mt. Rainier Md.

19. Jan 4 1945 (Date rec'd by registrar) Mrs. Jas. Severe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-4 1945 at 4:55 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-1 1945 to 1-4 1945 and that I last saw him alive on 1-3 1945

Immediate cause of death	DURATION
Acute Cardiac Dilatation	3 days
Due to Arteriosclerosis Heart Disease	10 years
Due to	
Other conditions Emphysema	15 years

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE U S Brennan M.D. M. D. or other
Address Mt. Rainier Md Date signed 1-5-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (79)

00747

CERTIFICATE OF DEATH

Reg. Diat. No. 230

1. PLACE OF DEATH:
County Pr. Geo. Co. Md
City or town Berwyn
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town Berwyn
(If outside city or town limits, write RURAL and give nearest town)
Street No. 9044 Balto Ave
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME John Marcellus Mangum

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widower

6.(b) Name of husband or wife Laura Mangum
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 7, 1855

8. AGE: Years	Months	Days	If less than one day
89			..... hrs. ..... min.

9. Birthplace Washington D.C.
(Town, county, and state)
10. Usual occupation None
11. Industry or business

FATHER
12. Name John Mangum
13. Birthplace Md

MOTHER
14. Maiden name Mary E. Harvey
15. Birthplace Md

16. Informant Ida M Fisher
Address Berwyn Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof JAN 30 1945 (month) (day) (year)
Cemetery or crematory St Johns
Location Bellsville Md

18. Funeral director F Grecchi sons
Address Hyattsville Md.

19. JANUARY 30th 1945 (Date rec'd by registrar) John D. Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 27 1945 at 2 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from General age 1945 to January 27 1945 and that I last saw h.... alive on recently 19....

Immediate cause of death	DURATION
Apoplexy	Hrs Min
Due to Chronic Nephritis	Several Years
Due to Senility	Several Years
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operations —
Date of op. —
Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of ....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?) —
Means of injury — Injured at work? —

23. SIGNATURE Dr. Allen Gilbert M. D. or other
Address Berwyn Md Date signed 1/28/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83d)

CERTIFICATE OF DEATH

00748 245

Reg. Diat. No. 243

1. PLACE OF DEATH:
County: Prince George
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death: 5 years
Hospital, institution, or street address where death occurred: 6509 Eastern Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Geo.
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6509 Eastern ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: JUANITA ELAINE MAYHEW

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Amos Mayhew
6.(c) If alive, give age: 40 years

7. Birth date of deceased (mo., day, yr.): Nov 23 1904

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
40	2	8		

9. Birthplace: DC (Town, county, and state)
10. Usual occupation: at home
11. Industry or business

FATHER
12. Name: Fenton W Crown
13. Birthplace: DC

MOTHER
14. Maiden name: Maude W Hess
15. Birthplace: DC

18. Informant: Amos Mayhew Park
Address: 6509 Eastern ave Takoma md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 3 1945 (month) (day) (year)
Cemetery or crematory: Evergreen
Location: Bladensburg md
18. Funeral director: F Gaeths Sons
Address: Hyattsville md

19. Jan 31 1945 (Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 31 1945, at 1930 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 24 1944, to Jan. 31 1945, and that I last saw h[illegible] alive on Jan. 30, 1945

Immediate cause of death: Progressive Paralysis — DURATION: 2½ yrs.
Due to: Some lesion of brain of undetermined cause
Due to: Character
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C B Little, M. D. or other
Address: 6911 5th st. NW. Washington DC. Date signed: Jan. 31/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23-0)

CERTIFICATE OF DEATH

00749

Reg. Diat. No. 245

1. PLACE OF DEATH:
County: Pro Geo Co
City or town: Kivardale md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 33 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Pro Geo Co
City or town: Kivardale md
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 5000 Rittenhouse st
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mary Elizabeth McKnew

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Nathan G. McKnew
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 17, 1883

8. AGE: Years	Months	Days	If less than one day
61			hrs. min.

9. Birthplace: Baltimore Md (Town, county, and state)
10. Usual occupation: housewife
11. Industry or business
FATHER 12. Name: Stephen Popke
13. Birthplace: Germany
MOTHER 14. Maiden name: Johanna Meisel
15. Birthplace: Baltimore, Md.
16. Informant: Nathan McKnew
Address: Kivardale md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 15/45, (month) (day) (year)
Cemetery or crematory: Fort Lincoln
Location: Colmar Manor Md
18. Funeral director: F. Gasche & Sons
Address: Hyattsville Md.
19. Jan 13 1945 (Date rec'd by registrar) Mrs. Ira Devere Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 11, 1945, at 7 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan-11- 1945 to Jan 11 1945
and that I last saw h[illegible] alive on Jan 11 1945

Immediate cause of death	DURATION
Apoplexy	1 hr
Due to: Cerebral Arteriosclerosis	
Due to: unknown	
Other conditions: none	

(Include pregnancy within 3 months of death)

Major findings of operations: none — Date of op.:
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: 4313 Gallatin St Hyattsville Md Date signed: Jan 12 45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (15?)

CERTIFICATE OF DEATH

00750 246

Reg. Diat. No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

1. PLACE OF DEATH:

County: Prince Georges

City or town: Lanesdale Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 hrs

Hospital, institution, or street address where death occurred:

Eugene Leland Memorial Hospital

How long in hospital or institution? 11 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Riverdale Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4408 Riverdale Rd Riverdale, Md

(If rural, give LOCATION)

2.(a) If veteran, name war: .....

3. (a) FULL NAME Joyce Meade

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 10, 1945

8. AGE: Years | Months | Days | If less than one day: 11 hrs. ..... min.

9. Birthplace: Riverdale Maryland (Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER — 12. Name: James Lee Meade

FATHER — 13. Birthplace: ?

MOTHER — 14. Maiden name: Ruby Ruth Spicer

MOTHER — 15. Birthplace: Virginia

16. Informant: Hospital records

Address: —

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-15-45 (month) (day) (year)

Cemetery or crematory: Geo. Wash. Mem. Cemetery

Location: .....

18. Funeral director: W W Chambers Co

Address: Riverdale Md.

19. Jan 14" 1945 (date rec'd by registrar) Mrs. Jas Severe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 10, 1945, at 11:30 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-10- 1945, to 1-10 1945

and that I last saw h.er alive on 1-10 1945

	DURATION
Immediate cause of death: Prematurity	11 Hours
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 8 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: L W Malin M.D. M. D. or other

Address: ..... Date signed .....

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (448)

00751

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:
County: Prince Georges
City or town: Brentwood Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 months
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: P. Geo's
City or town: N. Brentwood Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4525-41st. ave. [illegible]
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Eugene Fred Minor
3.(b) Social Security Number

4. Sex: Male
5. Color or race: C
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Annie Minor
6.(c) If alive, give age 35 years
7. Birth date of deceased (mo., day, yr.): Oct. 13, 1906.
8. AGE: Years 38 Months 3 Days 3 If less than one day ... hrs. ... min.
9. Birthplace: Savannah Georgia
(Town, county, and state)
10. Usual occupation: Elevator Operator
11. Industry or business: Building
FATHER 12. Name: John Minor
13. Birthplace: Georgia
MOTHER 14. Maiden name: Christina (unknown)
15. Birthplace: Georgia
16. Informant: Mrs Annie Minor (wife)
Address: 4525-41st. ave. Brentwood Md.
17. Removal Date thereof: Jan. 16 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory
Location: Washington, D.C.
18. Funeral director: John T. Stewart
Address: 30 H St. N.E. Wash. D.C.
19. Jan 16th 1945 Mrs. Jas. Sennie
(Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 16, 1945, at 5:45 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 11, 1945, to Jan. 16, 1945
and that I last saw him alive on Jan. 16, 1945

		DURATION
Immediate cause of death	Myocarditis	1 yr. ?
Due to	Collapse of circulatory system	12 hrs.
Due to	Hodgkin Disease	1943
Other conditions		

(Include pregnancy within 3 months of death)
Major findings of operations: Biopsy at Johns Hopkins Hosp. axillary gland Date of op. 1943
Autopsy results: Showed presence of Hodgkin's (?)
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?
Geo. W. Adams, M.D.
23. SIGNATURE: W. W. Siler M.D.
M. D. or other
Address: Brentwood, Md. Date signed 1-16-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

00752

Reg. Diat. No. 245

1. PLACE OF DEATH:
County: Prince Georges
City or town: Riverdale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? one day
Hospital, Institution, or street address where death occurred:
Leland Memorial Hospital
How long in hospital or institution? one day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Greenbelt
(If outside city or town limits, write RURAL and give nearest town)
Street No. 24 K Ridge Rd
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME John Robert Myers

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1-16-45

8. AGE: Years | Months | Days: 1 day | If less than one day: hrs. ..... min.

9. Birthplace: Riversdale, Prince Georges Md
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Frederick William Myers
13. Birthplace: Altoona, Pa

MOTHER
14. Maiden name: Marjorie Blunt
15. Birthplace: Williamsburg, Pa

16. Informant: mother
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-18-45 (month) (day) (year)
Cemetery or crematory: Mt. Olivet Cemetery
Location: Wash. D.C.

18. Funeral director: W. W. Chambers & Co
Address: Riverdale Md.

19. Jan 18 1945 (Date rec'd by registrar) James Seay Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-17 1945, at 5:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-16 1945, to 1-17 1945
and that I last saw h[illegible] alive on 1-17 1945 2:29

Immediate cause of death	DURATION
Respiratory Failure	
Due to: Pneumonia	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: William H. Leeuw Md
M. D. or other
Address: Greenbelt Md Date signed 1-18-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-21)

00753

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:
County Prince Geo. Gen. County Hospital
City or town Cheverly, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 28 hrs.
Hospital, institution, or street address where death occurred:
Prince Geo. Gen. Hospt.
How long in hospital or institution? 28 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Prince Geo.
City or town 4014 - 71st Ave., Landover Rd. Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Esther Halligan

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	widowed

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 12, 1873

8. AGE: Years 71 yrs | Months 11 Mo. | Days 25 | If less than one day hrs. min.

9. Birthplace Pennsylvia (Town, county, and state)

10. Usual occupation House work

11. Industry or business

FATHER
12. Name Murray Bukhune
13. Birthplace Pennsylvia

MOTHER
14. Maiden name Martha Thomas
15. Birthplace Pennsylvia

16. Informant Mrs. J. H. Krueger (daughter)
Address 4014 - 71st Ave. - Landover Rd - Md.

17. Transportation :- (Burial, cremation, or removal. Which?) Date thereof Jan 1945 (month) (day) (year)
Cemetery or crematory Neal Funeral Home
Location Pittsburg Pennsylvania

18. Funeral director L. Stasha Sons
Address Bladensburg Md

19. Jan. 8 1945 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-7 1945, at 2'7 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-4 1945, to 1-7 1945 and that I last saw her alive on 1-7 1945

Immediate cause of death	DURATION
Senile arterio-sclerosis - heart and kidney disease - Mal nutrition	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Geo. Hagenge M. D. or other
Address 3717 - 38th Ave Date signed 1-7-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-P)

00754

CERTIFICATE OF DEATH

Reg. Dist. No. 243.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Prince Georges

City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 mos., 28 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 8 mos., 28 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 2520 L. St. N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Emory D. Nichols

3.(b) Social Security Number: - ?

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male,	White	Married

6.(b) Name of husband or wife: Margaret Nichols

6.(c) If alive, give age: 37 years

7. Birth date of deceased (mo., day, yr.): Nov. 9, 1906

8. AGE: Years	Months	Days	If less than one day
38	2	22	....hrs. ....min.

9. Birthplace: Coeburn, Virginia
(Town, county, and state)

10. Usual occupation: Salesman

11. Industry or business:

FATHER
12. Name: J. N. Nichols
13. Birthplace: Gate City, Virginia

MOTHER
14. Maiden name: Nellie Counts
15. Birthplace: Coeburn, Virginia

16. Informant: Decedent.
Address:

17. Removal to (Burial, cremation, or removal. Which?) Date thereof: Jan. 31, 1945 (mouth) (day) (year)

Cemetery or crematory:

Location: Washington, D.C.

18. Funeral director: W. W. Chamberlin Co.

Address: 3072 M. St. N.W.

19. Jan. 31 1945 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 31 1945 at 5:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 3 1944, to Jan. 31 1945 and that I last saw h/ live on Jan. 31 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	8 mos.
Tuberculous meningitis	11 days
Due to Tuberculous osteomyelitis	7 mos.
Genito-urinary tuberculosis	1½ mos.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other

Address: Glenn Dale, Md. Date signed: Jan 31, 45

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00755

(131a)

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:

County: Prince Georges

City or town: Hyattsville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Sacred Heart Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Prince Georges

City or town: Hyattsville (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Margaret S. Nolan

3. (b) Social Security Number

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Widow

6. (b) Name of husband or wife: James J.

6. (c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): Dec 18 1864

8. AGE: Years 80 Months 1 Days 2 If less than one day ... hrs. ... min.

9. Birthplace: Woodstock Va. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER 12. Name: Timothy Shughrue

13. Birthplace: Ireland.

MOTHER 14. Maiden name: Mary Hargan

15. Birthplace: Ireland.

16. Informant: William Nolan

Address: 1202 - New York ave. NW

17. Removal (~~Burial, cremation~~, or removal. Which?) Date thereof: Jan 20, 1945 (month) (day) (year)

Cemetery or crematory

Location: Washington D.C.

18. Funeral director: W. W. Chambers Co

Address: 3072 - M st. N.W.

19. Jan. 20th 1945 (Date rec'd by registrar) Mrs. Jas. Severe, Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 20 1945, at 2:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1 1944 to Jan 20 1945

and that I last saw her alive on Jan 19th 1945

Immediate cause of death: Carditis [illegible] Arterio [illegible] [illegible] — DURATION: 6 months

Due to

Due to

Other conditions (Include pregnancy within 3 months of death): Acute dilatation of heart

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE: J. Chester Brady M. D. or other

Address: 35 - N.Y. Ave. Date signed: Jan 20/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-C)

00756

CERTIFICATE OF DEATH

Reg. Dist. No. 239

1. PLACE OF DEATH: (WITHIN CORPORATE LIMITS OF)

County: Anne Arundel

City or town: Laurel

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 51

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Anne Arundel

City or town: Laurel

(If outside city or town limits, write RURAL and give nearest town)

Street No. 320 Talbot Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Stephen G. Ake

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct 20 - 1860

8. AGE:

Years	Months	Days	If less than one day
84	2	29	..... hrs. ..... min.

9. Birthplace: Balto Md

(Town, county, and state)

10. Usual occupation: Merchant Retired

11. Industry or business: House Furnishings

FATHER

12. Name: Wm Carlyle Ake

13. Birthplace: Canonsburg Pa

MOTHER

14. Maiden name: Ellen E. Winston

15. Birthplace: East Liverpool Ohio

16. Informant: Carlyle Ake

Address: Laurel Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 20-1945 (month) (day) (year)

Cemetery or crematory: Loudon Park

Location: Baltimore Md

18. Funeral director: De Witt Donaldson

Address: Laurel Md

19. Jan 20 1945 M. Bradburn

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 18 1945 at 3:30 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 1937 to Jan 18 1945 and that I last saw h.... alive on June 7 8 1945

Immediate cause of death	DURATION
Softening of the brain (or c)	2 yr.
Due to Cerebral arteriosclerosis	5 yr.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Robert S McCreary M D (M.D. or other)

Address: 402 Main St Laurel Md Date signed: 1/20/45

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48-E)

00757

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH: County Pro Geo Co
City or town Tuxedo Md (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md County Pro Geo
City or town Tuxedo Md (If outside city or town limits, write RURAL and give nearest town)
Street No. 5004 Tuxedo Rd. (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Elizabeth W. Owens
3. (b) Social Security Number

4. Sex Female
5. Color or race white
6.(a) Single, married, widowed, or divorced Married.
6.(b) Name of husband or wife Joseph B Owens
6.(c) If alive, give age 53 years
7. Birth date of deceased (mo., day, yr.) May 31, 1889
8. AGE: Years 55 Months 7 Days 27 If less than one day 8 hrs. – min.
9. Birthplace Washington, D.C (Town, county, and state)
10. Usual occupation Maid
11. Industry or business

FATHER
12. Name Fredrick Arnold
13. Birthplace Germany

MOTHER
14. Maiden name Elizabeth Dinges
15. Birthplace Washington. D.C

16. Informant Mrs Josephine Butler
Address 5004 Tuxedo Rd, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 2, 1945 (month) (day) (year)
Cemetery or crematory Fort Lincoln
Location Colmar Manor Md

18. Funeral director F Gasch's sons
Address Hyattsville Md

19. Jan. 29 1945 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-28 1945, at 8 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 10-20 1944, to 1-28 1945
and that I last saw h... alive on ... 19...

Immediate cause of death Carcinoma of uterus
Generalized carcinoma
DURATION
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE George J Hageage M. D. or other
Address 3711 - 38th St Av Date signed 1-28-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95-e)

CERTIFICATE OF DEATH

00759

Reg. Dist. No. 245

1. PLACE OF DEATH:
County Prince Georges
City or town Hyatts ville Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Five months
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town Hyatts ville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4615 Burlington Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Sarah A Owens

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife James L. Owens

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 15, 1855

8. AGE:

Years	Months	Days	If less than one day
89	11	15	..... hrs. ..... min.

9. Birthplace Frederick County Va.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own Home

FATHER
12. Name John M Shryock
13. Birthplace unknown

MOTHER
14. Maiden name Jane E. Shryock
15. Birthplace unknown

16. Informant Mrs L. Owens
Address Berryville Va.

17. Removal (Burial, cremation, or removal. Which?) Date thereof Jan 31 1945 (month) (day) (year)

Cemetery or crematory
Location Berryville Va.

18. Funeral director Charles J. Sanders
Address Berryville Va.

19. Jan 31 1945 (Date rec'd by registrar) Mrs Jas Severe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 30 1945 at 8.37 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-16 1945, to 1-30 1945, and that I last saw her alive on 1-28 1945

	DURATION
Immediate cause of death Acute cardiac failure	1 hour
Due to Senility	2 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W B Meyers M. D. or other
Address Mt. Rainier Md Date signed 1/31/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (5+6)

CERTIFICATE OF DEATH

00758

Reg. Diat. No. 3 30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH

County: Prince George

City or town: Berwyn med

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution? 18 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: County:

City or town:

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Rameses Oland Philips

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife: Adelaide L. Philips

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec - 25 - 1865

8. AGE: Years	Months	Days	If less than one day
79			hrs. min.

9. Birthplace: Fla. (Town, county, and state)

10. Usual occupation: Retired Salesman

11. Industry or business

FATHER 12. Name: Andrew Jackson Philips

13. Birthplace: Jones Co. Georgia

MOTHER 14. Maiden name: Rachel J. Blake

15. Birthplace: St. Marys Co. Fla (or Ga.)

16. Informant: Roland O. Philips

Address: 5815 Branchville Rd Berwyn med

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1 - 20 - 45 (month) (day) (year)

Cemetery or crematory: George Washington Mem Md.

Location:

18. Funeral director: W W Chambers Co

Address: Riverdale med

19. Jan - 19th 1945 (Date rec'd by registrar) Thos D Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 18 1945, at 10:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-16 1945, to 1-18 1945 and that I last saw h.l.m. alive on 1-18 1945

Immediate cause of death	DURATION
Respiratory failure	
Due to: Carcinomatosis	
Due to: Carcinoma prostate	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: William Eisner MD M. D. or other

Address: 30 B. Ridge Rd Greenbelt md Date signed 1-18-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1579

00760

CERTIFICATE OF DEATH

Reg. Diat. No. 231

1. PLACE OF DEATH:
County: Prince George
City or town: Cheverly - Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 days
Hospital, institution, or street address where death occurred: Prince George General Hospital
How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Prince George's
City or town: DeCatur Heights
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5007 - Upshur ST.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: James Emmett Prentiss.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	w	Mar'd.

6.(b) Name of husband or wife:
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Jan. 17. 1945

8. AGE: Years | Months | Days: 3 | If less than one day: hrs. min.

9. Birthplace: Cheverly, Prince Geo. County, Maryland
(Town, county, and state)
10. Usual occupation:
11. Industry or business:
FATHER 12. Name: Walter C. Prentiss
13. Birthplace: Washington DC.
MOTHER 14. Maiden name: Eleanor A. Mead
15. Birthplace: Washington, D.C.
16. Informant: Eleanor Mead Prentiss.
Address: 5007 Upshur ST. DeCatur Heights Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 22, 1945 (month) (day) (year)
Cemetery or crematory: Fort Lincoln
Location: Colmar Manor Md
18. Funeral director: F Giachia Sons
Address: Bladensburg Md
19. Jan. 22 1945 (Date rec'd by registrar) Amanda Danner Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1-20 1945, at 10 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h... alive on 1-20 1945

	DURATION
Immediate cause of death: Tuberculosis	
Due to: Congenital bad heart.	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: George Magruder M.D. or other
Address: 3217-38th St. Date signed: 1-20-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00761

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince George's
City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 mos., 24 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 10 mos., 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2311 G. St. N. E.
(If rural, give LOCATION)
2.(a) If veteran, name war: –

3.(a) FULL NAME: LEMIRE PRICE

3.(b) Social Security Number: 228-12-0353

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife: Eugene Price
6.(c) If alive, give age: 22 years

7. Birth date of deceased (mo., day, yr.): February 3, 1924

8. AGE: Years	Months	Days	If less than one day
20	9	28	....hrs. ....min.

8. Birthplace: Whitakers, North Carolina (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: –

FATHER
12. Name: Joseph Williams
13. Birthplace: Whitakers, North Carolina

MOTHER
14. Maiden name: Arkie ? Williams
15. Birthplace: Whitakers, North Carolina

16. Informant: Decedent
Address

17. Jan 2 1945 (Burial, cremation, or removal. Which?) Date thereof 1/2/45 (month) (day) (year)
Cemetery or crematory: Cremorial
Location: Wash. D.C. Then Richmond Va.
18. Funeral director: R. J. Crosby
Address: 1226 Conn Ave. N.W.
19. Jan. 1, 1945 (Date rec'd by registrar) Rowland S. Phillips Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 1 1945 at 12:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 7, 1944, to Jan 1 1945
and that I last saw her alive on Jan 1 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	20 MO
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other
Address: Glenn Dale, Md. Date signed 1/1/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (15-P)

00762

CERTIFICATE OF DEATH

Reg. Diat. No. 243

1. PLACE OF DEATH:
County: Prince George's
City or town: Rural route, Glen Dale Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 6 mo's, 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6411 - Eastern ave.,
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME Edward Pulliam

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Wh.	single

6.(b) Name of husband or wife: —
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 5, 1919

8. AGE: Years: 25 | Months: 9 | Days: 14 | If less than one day: hrs. min.

9. Birthplace: ~~Spain~~ Remington Co., Va.
(Town, county, and state)

10. Usual occupation: dairyman

11. Industry or business: —

FATHER
12. Name: Charles W. Pulliam
13. Birthplace: Spervin, Va.

MOTHER
14. Maiden name: May Spicer
15. Birthplace: Spervine, Va

16. Informant: Deceased
Address

17. Removal to (Burial, cremation, or removal, Which?) Date thereof: Jan 17 1945 (month) (day) (year)
Cemetery or crematory
Location: Washington, D.C.

18. Funeral director: W. W. Chamberco.
Address: 1400 Chapin St. NW.

19. Jan 17, 1945 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 17 1945, at 2-05 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 30 1944, to Jan 17 1945
and that I last saw h.i.m. alive on Jan 17 1945

Immediate cause of death: Pulmonary Tuberculosis — DURATION: 7 months

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Pincane M.D. M. D. or other
Address: Glen Dale, Md. Date signed: 1-17-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(M)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(131-a)

CERTIFICATE OF DEATH

06763

Reg. Dist. No. 234

1. PLACE OF DEATH:

County Prince Georges

City or town Camp Springs

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Branch Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State Maryland County Prince George

City or town Camp Springs

(If outside city or town limits, write RURAL and give nearest town)

Street No. Branch Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Ross Clifton Pyles

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	Divorced

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 31, 1891

8. AGE: Years 53 | Months 9 | Days 14 | If less than one day ..... hrs. ..... min.

9. Birthplace Camp Springs Md

(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name Wallace P Pyles

13. Birthplace Maryland

MOTHER 14. Maiden name Celeste Jane Adams

15. Birthplace Maryland

16. Informant Mrs Ruth Apron

Address 6271 - Branch Ave S E

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-16-1946 (month) (day) (year)

Cemetery or crematory Bell's Ch. Cemetary

Location Camp Springs, Md

18. Funeral director Wm. H. Leath

Address 409 - 8th. St. S.E. DC

19. Jan. 14 1946 Howard J Beall

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 14 1946, at 5:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute Intestine	
heart failure	
Due to Cardiovascular	
renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Deputy medical Examiner

23. SIGNATURE ..... M. D. or other

Address Forestville Md Date signed 1-15-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-C)

00764

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:

County: Prince Georges

City or town: College Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Permanent

Hospital, Institution, or street address where death occurred: Harvard Drive

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 112 Varnum St NW

(If rural, give LOCATION)

3.(a) If veteran, name war: ✓

3. (a) FULL NAME: Edmond S. Reynolds

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 20, 1899

8. AGE: Years: 45 | Months: 6 | Days: 14 | If less than one day: hrs. min.

9. Birthplace: Delhia, N. Y. (Town, county, and state)

10. Usual occupation: Soil Conservation

11. Industry or business: U. S. Dept Agriculture

FATHER — 12. Name: George W. Reynolds

FATHER — 13. Birthplace: New York

MOTHER — 14. Maiden name: Minnie Stoddard

MOTHER — 15. Birthplace: New York

16. Informant: Mrs Paul Conkling

Address: 112 Varnum St. Washington D.C.

17. Removal (Burial, cremation, or removal, which?) Date thereof: Jan 4, 1945 (month) (day) (year)

Cemetery or crematory: Hines Funeral Home

Location: Washington, D. C.

18. Funeral director: J. Gasch's Sons

Address: Hyattsville, Md.

19. Jan 4 1945 (Date rec'd by registrar) Jas Severy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 4 1945, at 7.50 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h... alive on ..... 19.....

Immediate cause of death	DURATION
(a) Compressed Spinal cord	
Due to (b) Fractured cervical dislocation C 6 and 7th Cervical vertebrae	
Due to (c)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 1-4-45

Where did injury occur? College Park P.G. Md (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Harvard Drive

Means of injury: Pedestrian struck by car Injured at work? No

Deputy medical examiner

23. SIGNATURE: ..... M. D. or other

Address: Forestville Md Date signed: 1-4-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for change of age of deceased is shown on FILM No G 92 MAR 10 1945

00765

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (19-Q)

CERTIFICATE OF DEATH

Reg. Diat. No. 231

1. PLACE OF DEATH:
County: Prince George
City or town: Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 16 days
Hospital, institution, or street address where death occurred: Prince George General Hospital
How long in hospital or institution? 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George
City or town: Landover
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Florence Ridley

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 2 1883

8. AGE: Years	Months	Days	If less than one day
61 ~~62~~	3	14	..... hrs. ..... min.

9. Birthplace: Harvard, Co. (Town, county, and state) Md.
10. Usual occupation: Housewife
11. Industry or business: own Home
FATHER 12. Name: Charles Spencer Ward
13. Birthplace: md
MOTHER 14. Maiden name: Laura Hart
15. Birthplace: md.
16. Informant: Nita Mazon
Address: Landover, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 19, 1945 (month) (day) (year)
Cemetery or crematory: Fort Lincoln
Location: Colmar Manor Md
18. Funeral director: E. Gaeckler sons
Address: Hyattsville Maryland.
19. Jan. 18 1945 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 16 1945, at 5 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 12 1944, to Jan. 16 1945
and that I last saw her alive on Jan. 16 1945

	DURATION
Immediate cause of death: Uremia	6 days
Due to: Cardio-Vassular - Renal Disease	5 years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Charles C. Hageage M.D.
M. D. or other
Address: Mt. Rainier, Md. Date signed: Jan. 16, 1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MAYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

00766

Reg. Dist. No. 231

1. PLACE OF DEATH:
County 4006-29 st mt Rainier
City or town md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State md County Prince George
City or town mt Rainier md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4006-29 th st
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME WILLIAM SCOTT RINEHART
3. (b) Social Security Number

4. Sex M
5. Color or race W
6.(a) Single, married, widowed, or divorced Widower
6.(b) Name of husband or wife Mary M Dead
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) June 23, 1876
8. AGE: Years 68 Months — Days — If less than one day ... hrs. ... min.
9. Birthplace Maryland
(Town, county, and state)
10. Usual occupation Retired (officer)
11. Industry or business
FATHER 12. Name David Rinehart
13. Birthplace Maryland
MOTHER 14. Maiden name Mary Stockslager
15. Birthplace Maryland
16. Informant Lloyd Rinehart
Address 4006-29-st md.
17. Removal Date thereof Jan 3, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Wash. D.C.
Location
18. Funeral director The S. H. Hines Co.
Address 2901-14 st NW Washington
19. Jan 1 1945 [signature] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 1, 1945 3 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 1944, to Jan 1 1945
and that I last saw him alive on Jan 1 1945
Immediate cause of death Cerebral Hemorrhage — DURATION 3 days
Due to Arterio Sclerosis — 10 years
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other
Address 1927 N Cap St. Wash. D.C. Date signed Jan 1/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (15)

00767

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:

County: Prince Georges

City or town: Riverdale Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 hrs

Hospital, institution, or street address where death occurred: Eugene Leland Memorial Hospital

How long in hospital or institution? 8 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Greenbelt

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 39 F Ridge Rd

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Roberta Mae Rochling

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): January 9 1945

8. AGE: Years | Months | Days | If less than one day: 8 hrs. ____ min.

9. Birthplace: Riverdale Maryland (Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER — 12. Name: Charles Henry Rochling

FATHER — 13. Birthplace: Ireland

MOTHER — 14. Maiden name: Viola Jane Hoffett

MOTHER — 15. Birthplace: Michigan

19. Informant: Hospital record

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: JAN 11, 1945 (month) (day) (year)

Cemetery or crematory: Evergreen

Location: Bladensburg Md

18. Funeral director: F Gaeta & Sons

Address: Hyattsville Md

19. Jan 11 1945 (Date rec'd by registrar) Mrs. Jas. Devere Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 10 19 45 at 4 15 a.m. P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19____, to ____ 19____

and that I last saw her alive on 1-10 19 45

Immediate cause of death	DURATION
Respiratory failure	
Prematurity	
Due to: Prematurity - 7 hrs.	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: ____ Injured at work?

23. SIGNATURE: William Linnen Jr M. D. or other

Address: Greenbelt Md Date signed: 1-10-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00768

CERTIFICATE OF DEATH

Reg. Diat. No. 231

1. PLACE OF DEATH:
County: Prince Geo Gen. Hosp.
City or town: Prince Geo Co
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 days.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Prin Geo
City or town: 5311 Taylor St.
(If outside city or town limits, write RURAL and give nearest town)
Street No. Riverdale, Md.
(If rural, give LOCATION)
2.(a) If veteran, name war: World War I

3.(a) FULL NAME: Charles L. Rooney.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs E. Rooney
6.(c) If alive, give age: 41 years

7. Birth date of deceased (mo., day, yr.): April 21, 1894

8. AGE: Years	Months	Days	If less than one day
50	—	—	....hrs. ....min.

9. Birthplace: N. Y. (Town, county, and state)
10. Usual occupation: Plate Printer
11. Industry or business: Bureau of engraving
FATHER 12. Name: Charles E. Rooney
13. Birthplace: N. Y.
MOTHER 14. Maiden name: Mary E. Rooney
15. Birthplace: Riverdale, Md
16. Informant: Mrs Evelyn Rooney
Address: Rivaldale Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 29, 1945 (month) (day) (year)
Cemetery or crematory: Fort Lincoln
Location: Colmar Manor Md
18. Funeral director: F Gascte sons
Address: Hyattsville Md.
19. Jan 26 1945 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1 — 25 — 1945 at 1:30 P. M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 1 1940, to Jan 25 1945
and that I last saw h... alive on Jan 25 1945
Immediate cause of death: Perforation of Peptic Ulcer
Due to: Stomach
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

DURATION
Yrs.

Major findings of operations: ....Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Hyattsville, Md Date signed: 1/26/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)(a)

00769

CERTIFICATE OF DEATH

Reg. Dist. No. 242

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Prince Geo.
City or town: Silver Hill, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Geo.
City or town: Silver Hill
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 4600 Walnut ave. S.E.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: CHARLES LOUIS RUPPERT SR.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Widower

6.(b) Name of husband or wife: Martha F. RUPPERT
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 7th 1860

8. AGE: Years	Months	Days	If less than one day
84			..... hrs. ..... min.

9. Birthplace: Wadenbach, Germany.
(Town, county, and state)
10. Usual occupation: none
11. Industry or business: none

FATHER
12. Name: RUPPERT
13. Birthplace: Germany

MOTHER
14. Maiden name: Catherine Harman
15. Birthplace: Germany

16. Informant: Mrs. Martha Ruppert
Address: 4620 Walnut ave. Silver Hill

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof: 2 (month) 4 (day) 45 (year)
Cemetery or crematory: Hyattsville Md
Location: Washington D.C.
18. Funeral director: H. H. Chambers Jr.
Address: 317-11th St. S.E.
19. Jan 31 1945 (Date rec'd by registrar) Irene A. Conner Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 30 1945 at 7 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 29 1945 to Jan 30 1945 and that I last saw h. alive on Jan 29 1945

Immediate cause of death	DURATION
(a) Acute myocardial failure	1 hour
Due to: (b) Acute Congestive Heart failure	
Due to: (c) Cardiovascular	unknown
Due to: (d) Renal disease	
Due to: (e) General Arteriosclerosis	unknown
Other conditions: Hypertrophy of Prostate with Some retention of urine	unknown

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.:
Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no
Accident, suicide, or homicide: Date of: —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: — Injured at work? —

23. SIGNATURE: [signature] M. D. or other
Address: Washington 19 Date signed: Jan Dec. 1 30 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-2)

CERTIFICATE OF DEATH

011779

Reg. Dist. No. 230

1. PLACE OF DEATH: Prince George

County: Prince George

City or town: (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) Pr Geo

State: Md County:

City or town: Berwyn Heights (If outside city or town limits, write RURAL and give nearest town)

Street No. 5712 Queen (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Edmee Sebastien

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

8.(b) Name of husband or wife: Charles Sebastien

8.(c) If alive, give age: dead years

7. Birth date of deceased (mo., day, yr.): Feby 19th 1895

8. AGE:

Years	Months	Days	If less than one day
49	10	20	..... hrs. ..... min.

9. Birthplace: Montreal Canada (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Joseph Leroux

13. Birthplace: Canada

MOTHER — 14. Maiden name: Blanche G Hereux

15. Birthplace: New Orleans La

16. Informant: Mrs J R Prestons

Address: Berwyn Heights

17. Burial (Burial, cremation, or removal. Which?) Date thereof: JAN 11 1945 (month) (day) (year)

Cemetery or crematory: Fort Lincoln

Location: Colmar Manor Md

18. Funeral director: F Gasche Sons

Address: Hyattsville Md

19. January 10th 1945 (Date rec'd by registrar) John D Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 9th 1945, at 9:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 9th 1945 to January 9 1945

and that I last saw her alive on January 9 1945

Immediate cause of death	DURATION
Carcinoma of Pancreas	2 yrs +
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Colostomy Date of op. May 1944

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: M D Etienne M. D. or other

Address: Berwyn Md Date signed 1/9/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-a)

00771

CERTIFICATE OF DEATH

Reg. Diat. No. 2440

1. PLACE OF DEATH:
County: Prince Geo.
City or town: Brandywine Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Prince Geo
City or town: Brandywine md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war.

3.(a) FULL NAME: David M. Shaw

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Md

6.(b) Name of husband or wife.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct 4 - 1895

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
55	3	6		

9. Birthplace: Washington Dc
(Town, county, and state)
10. Usual occupation: Seamstress
11. Industry or business

FATHER
12. Name: Aroria Shaw
13. Birthplace: White Plains md

MOTHER
14. Maiden name: Virgie Roby
15. Birthplace: White Plains Md

16. Informant: Mrs Virgie Shaw
Address: Brandywine md

17. Burial (Burial, cremation, or removal. What?) Date thereof 1-9-45 (month) (day) (year)
Cemetery or crematory: St Pauls Piney
Location: Mr Waldorf md
18. Funeral director: Hunt & Ryon
Address: Waldorf md
19. 1-7 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1/7 1945, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1944, to 1/7 1945
and that I last saw h... alive on 1/2 1945

Immediate cause of death: Cardiac Decompensation — DURATION: 4
Due to: Cardio-Vas Renal Disease — 3 4 years
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Chas A. Worden M. D.
M. D. or other
Address: Waldorf Md Date signed: 1/7/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-A)

CERTIFICATE OF DEATH

001772

Reg. Dist. No. 246

1. PLACE OF DEATH:
County PRINCE GEORGES
City or town HYATTSVILLE
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 1/2 MONTHS
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County PRINCE GEORGES
City or town HYATTSVILLE
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5705 - 36TH. AVE.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME LILLIAN K. SHINE

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	WIDOW

6.(b) Name of husband or wife PATRICK F. SHINE
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 12/19/71

8. AGE: Years	Months	Days	If less than one day
73			hrs. min.

9. Birthplace PENN. (Town, county, and state)
10. Usual occupation HOUSEWIFE
11. Industry or business
FATHER 12. Name JOHN E LYLE
13. Birthplace PENN
MOTHER 14. Maiden name NANCY J. SPAULDING
15. Birthplace PENN
18. Informant LILLIAN K. SHINE
Address 1302 SHEPHERD ST. N.W. WASHINGTON D.C.
17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 1-12-44 (month) (day) (year)
Cemetery or crematory ST. JOSEPH'S CEMETERY
Location WARREN, PENN
18. Funeral director Francis J. Collins
Address 3821 - 14th St. N.W. Washington
19. Jan 11th 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 11 1945, at 3:20 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary occlusion	
Due to Cardiosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?
23. SIGNATURE Deputy medical Examiner M. D. or other
Address Hyattsville Md. Date signed 1-11-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

STATE OF MARYLAND—CERTIFICATE OF DEATH

00773

1. PLACE OF DEATH (43)

County Prince George Registration Dist. No. 230

Village or City Muirkirk Md No. St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. 1 mos. 2 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Dilje May Stratford If U. S. Veteran, specify WAR

(a) Residence: No. St., Ward.
(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
Female	Colored	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, and year) Dec 20 1944

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	2	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Muirkirk Md.
(State or country)

FATHER

13. NAME Jessie Stratford

14. BIRTHPLACE (city or town) Muirkirk Md
(State or country)

MOTHER

15. MAIDEN NAME Clara V. Matthews

16. BIRTHPLACE (city or town) Laurel Md
(State or country)

17. INFORMANT Jessie Stratford
(Address) Muirkirk Md

18. BURIAL, CREMATION, OR REMOVAL
Place Muirkirk Md Date Jan 23, 1946

19. UNDERTAKER Ridgely Selby
(Address) 401 Main Ave Laurel Md

20. FILED Jan 23rd, 1945 John D. Smith
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH January 22 (Month) (Day), 1945 (Year)

22. I HEREBY CERTIFY, That I attended deceased from Dec 30, 1945, to Jan 22, 1945

I last saw her alive on January 22, 1945; death is said to have occurred on the date stated above, at 4:00 P.M.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Thrush (1156)	12/30/44

Other **Contributory Causes** of importance:

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy? No

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur?
(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of Injury

Nature of Injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Robert L McGregor M. D.

1/23/45 (Address) 402 Main St Laurel Md

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I		Example II	
The principal cause of death and related causes of importance were as follows:	Date of onset	The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*	*Attack of epilepsy*	*1 week ago*
Chronic interstitial nephritis	*1921*	*Run over by street car*	*1 week ago*
Cerebral hemorrhage	*July 5, 1927*	*Peritonitis*	*3 days ago*
Other contributory causes of importance:		Other contributory causes of importance:	
Gallstones	*May 1, 1923*	*Gastroenteritis*	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

Deal

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1572)

CERTIFICATE OF DEATH

111774

Reg. Dist. No. 243

1. PLACE OF DEATH:
County Prince Georges
City or town Riverdale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 days
Hospital, institution, or street address where death occurred:
Eugene Leland (X) emorial Hosp. Riverdale Md.
How long in hospital or institution? 5 days - 1 hr. 7 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland. County Prince Georges.
City or town University Pk.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4321 Woodberry St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Baby Susan Sullivan

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female.	white	infant.

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) December 28, 1944

8. AGE: Years | Months | Days: 5 | If less than one day: 1 hrs. 7 min.

9. Birthplace Riverdale, Prince Georges Co. Maryland
(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER
12. Name Joseph W. Sullivan.
13. Birthplace Worcester Co. Mass
MOTHER
14. Maiden name Susan Pearl Auldridge.
15. Birthplace Pocahontas Co. West Va.

16. Informant Father - Dr. Jos. W. Sullivan
Address 4321 Woodberry St. University Pk. Md.

17. Burial (Burial, cremation, or removal. Which) Date thereof Jan 3 1945 (month) (day) (year)
Cemetery or crematory Fort Lincoln
Location

18. Funeral director Deal Funeral Homes
Address 4812 Ga. Ave. N.W. Wash. D.C.

19. Jan. 2 1945 Rosamondas Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 2 1945, at 3:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 28 1944, to Jan. 2 1945 and that I last saw h.e.r. alive on Jan. 2 1945

	DURATION
Immediate cause of death: Congenital Heart Disease (Defect in inter ventricular septum)	5 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op.

Autopsy results autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. E. Malin, M.D. M. D. or other
Address Riverdale, Md. Date signed 1/2/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00775

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince George's
City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 29 Myrtle St. N. E.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Louis Thomas

3.(b) Social Security Number: lost

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Mazzie Thomas
6.(c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): April 14, 1884

8. AGE: Years	Months	Days	If less than one day
60	8	26	...hrs. ...min.

9. Birthplace: Montgomery Co., Maryland (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business

FATHER
12. Name: John Thomas
13. Birthplace: Montgomery Co.,, Maryland

MOTHER
14. Maiden name: Harriet Hyson
15. Birthplace: Arlington, Virginia

16. Informant: Decedent
Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof 1 9 45 (month) (day) (year)
Cemetery or crematory: Ft Washington Md-C
Location

18. Funeral director: Barbour Brothers
Address 48-K St. N. E.

19. Jan 9 1945 Rowland S. Phillips (Date rec'd by registrar) By [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 9 1945, at 6:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 22, 1944, to January 9 1945 and that I last saw him alive on January 9 1945

Immediate cause of death	DURATION
Bronchopneumonia	5 mos.
Due to: Tuberculosis	
Due to: Tuberculous Laryngitis	2 mos.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. (M. D. or other)
Address: Glenn Dale, Md. Date signed: 1/10/45

(M) (I) MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (164-C)

CERTIFICATE OF DEATH

Reg. Dist. No. 10776 245

1. PLACE OF DEATH:

County Prince Georges

City or town Hyattsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months

Hospital, Institution, or street address where death occurred: 5205 - Baltimore Blvd

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Hyattsville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5205 - Baltimore Blvd

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Thomas Wilbert Thomassen **3. (b) Social Security Number**

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 29, 1920

8. AGE:

Years	Months	Days	If less than one day
24	7	8	..... hrs. ..... min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual occupation Messenger

11. Industry or business Bank

FATHER

12. Name Freeman Thomassen

13. Birthplace North Carolina

MOTHER

14. Maiden name Julia Dann

15. Birthplace North Carolina

16. Informant Catherine Thomassen

Address 5205 - Baltimore Blvd

17. Disposition: Cremation Date hereof: January 7, 1945 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Avery Funeral Home

Location Smithfield, North Carolina

18. Funeral director J. Frasier Sons

Address Hyattsville, Md.

19. January 6 1945 Mrs. Jas. Severe Deputy Local Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 6, 1945, at 8:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Hemorrhage and shock	
Due to: Two gun shot wounds through left chest	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Homicide Date of 1-6-45

Where did injury occur? Hyattsville (City or town) P.G. (County) Md. (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury Gun - shot, injured at work? No

Deputy medical Examiner

23. SIGNATURE [signature] M. D. or other

Address Forestville Md. Date signed 1-6-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (30)

00777

CERTIFICATE OF DEATH

Reg. Dist. No. 224

1. PLACE OF DEATH:
County: Prince George
City or town: Fort Foote, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prs. Geo. Co.
City or town: Fort Foote Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Elsie Ruth Thorne

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept 11 - 1930

8. AGE: Years: 14 | Months | Days | If less than one day: hrs. min.

9. Birthplace: Fort Foote md (Town, county, and state)

10. Usual occupation: Student

11. Industry or business:

FATHER
12. Name: George F Thorne
13. Birthplace: Delesia md

MOTHER
14. Maiden name: Mary L Scheer
15. Birthplace: Wash DC.

16. Informant: George F Thorne
Address: Fort Foote md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb - 1st 1945 (month) (day) (year)
Cemetery or crematory: Cedar Hill. Pomfret
Location: Suitland md.

18. Funeral director: Thomas F Murray
Address: 2007 - Nichols ave S.E.

19 Jan 30 1945 Howard J Beall
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 30 19 45, at 4 a.m. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 1944 19 to Jan. 30 19 45
and that I last saw h.. alive on Jan. 27, 19 45

	DURATION
Immediate cause of death: acute	
Underlying cause: hemmorrhagic	
Contributory: nephritis	
Due to: acute [illegible] myocarditis	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: 2015 - Nichols ave. S.E. Date signed: Jan. 30 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

0077?

Reg. Dist. No. 242

1. PLACE OF DEATH:
County: Prince Georges
City or town: Lanham
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 years
Hospital, institution, or street address where death occurred:
Lanham Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Lanham
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Lanham Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Dudley William Washington Turner **3.(b) Social Security Number:**

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	married

6.(b) Name of husband or wife: Millie E. Turner
6.(c) If alive, give age: 64 years

7. Birth date of deceased (mo., day, yr.): Oct 3, 1879

8. AGE: Years	Months	Days	If less than one day
65	3	22	hrs. min.

9. Birthplace: Charles Co. Md.
(Town, county, and state)
10. Usual occupation: Plasterer
11. Industry or business
FATHER 12. Name: Johnson Henry Turner
13. Birthplace: Maryland
MOTHER 14. Maiden name: Anna Rhodes
15. Birthplace: Maryland
16. Informant: Millie E. Turner
Address: Lanham, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 29 1946 (month) (day) (year)
Cemetery or crematory: Lincoln Memorial
Location: Suitland Md
18. Funeral director: E B Thompson
Address: Annapolis
19. Jan 29 1945 (Date rec'd by registrar) Mrs Jack Bennette Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 26 1945 at 12:40 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Cardiovascular renal disease	
Due to: Congestive heart failure	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?
Deputy medical examiner
23. SIGNATURE: James D. Long M.D. or other
Address: Forestville Md Date signed 1-27-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-b-)

00778

CERTIFICATE OF DEATH

Reg. Diat. No. 231

1. PLACE OF DEATH:

County Prince George's

City or town Lakeland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address (if not in hospital or institution):

4702 Lakeland Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Lakeland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4702 - Lakeland Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Harry Wallace

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Colored	married

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 24, 1878

8. AGE: Years 66 | Months 1 | Days 4 | If less than one day ... hrs. ... min.

9. Birthplace Washington, D.C. (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name Harry Wallace

13. Birthplace District of Columbia

MOTHER 14. Maiden name Unknown

15. Birthplace Unknown

16. Informant Helen Foreman

Address Lakeland, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 2, 1945 (month) (day) (year)

Cemetery or crematory Arlington Nat. Cem.

Location Arlington, Va

18. Funeral director A. Gaschis Sons

Address Hyattsville, Md

19. Feb. 2 1945 Amanda Dawson Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 28 1945 at 7:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...

and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Generalized metastasis	
Due to Carcinoma of the Stomach	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings at operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Deputy medical Examiner M. D. or other

Address Forestville Md Date signed 1-28-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

00780

Reg. Dist. No. 245

1. PLACE OF DEATH:

County: Prince George

City or town: Hyattsville md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Prince Geo.

City or town: Hyattsville
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3901 Oliver st
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME FRANK WILCOX

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Carrie Wilcox

6.(c) If alive, give age: 80 years

7. Birth date of deceased (mo., day, yr.): July 21 1865

8. AGE: Years	Months	Days	If less than one day
79	6	7	hrs. min.

9. Birthplace: N Y
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER 12. Name: Russell Wilcox

13. Birthplace: N.Y.

MOTHER 14. Maiden name: Burbee

15. Birthplace: N Y

16. Informant: Edmond L Hayre

Address: 3901 Oliver St Hyattsville md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 16 1945 (month) (day) (year)

Cemetery or crematory: Geo Washington Memorial Park

Location: Berwyn md

18. Funeral director: L Gaudalis Sons

Address: Hyattsville md

19. Jan 16 1945 (Date rec'd by registrar) Mrs Jas. Devine Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 14 1945, at 9 10 AM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 1-10-45 19.., to 1-14-45 19..

and that I last saw h.. l.. alive on 1-13-45 19..

Immediate cause of death: Coronary Thrombosis — DURATION: 4 days

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: John P. Clum M.D.
M. D. or other

Address: Hyattsville Md Date signed: 1-14-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00781

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Prince George
City or town: Chesterville Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 hrs 20 min
Hospital, institution, or street address where death occurred: Prince George General Hosp
How long in hospital or institution? 3 hrs 20 min

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Pr. George
City or town: Accokeek
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3.(a) FULL NAME: William Edward Willett

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Widowed

6.(b) Name of husband or wife: Mamie Willett
6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): 1873

8. AGE: Years: 72 ? Months: July Days: 1 If less than one day: hrs. min.

9. Birthplace: Charles Co. Maryland (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER
12. Name: William Willett
13. Birthplace: Charles Co. Md.

MOTHER
14. Maiden name: ? — Mc. Daniel
15. Birthplace: ?

16. Informant: Mrs Eva Renno
Address: Accokeek Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/13/45 (month) (day) (year)
Cemetery or crematory: Oakland
Location: Waldorf, Md
18. Funeral director: Hunt & Pyon
Address: Waldorf, Md.

19. Jan. 11 1945 (Date rec'd by registrar) Amanda Denney Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 10 19 45, at 7 55/60 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Congestive heart failure	
Due to: Toxemia of pregnancy	
Due to: Pneumonia - labor	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results: ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: Deputy medical Examiner M. D. or other
Address: Prestwould Date signed 1-10-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (183)

00782

CERTIFICATE OF DEATH

Reg. Diat. No. 234

1. PLACE OF DEATH:
County: Prince Georges
City or town: Oxon Hill
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Broad Creek
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Oxon Hell
(If outside city or town limits, write RURAL and give nearest town)
Street No. 7403 - Oxon Hell Rd
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Eben Williamson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Emma P Williamson
6.(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): May 10, 1871

8. AGE: Years	Months	Days	If less than one day
73	8	8	hrs. min.

9. Birthplace: Fauquier County, Va
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business

FATHER
12. Name: Williamson
13. Birthplace: Virginia

MOTHER
14. Maiden name: Wilson
15. Birthplace: Virginia

16. Informant: Mrs Elizabeth Majors
Address: 3015 Nicholas Ave S.E. DC

17. Burial (Burial, cremation, or removal? Which?) Date thereof: Jan 22-1945 (month) (day) (year)
Cemetery or crematory: Cedar Hill Cemetery
Location: Suitland Maryland
18. Funeral director: Thomas F Murray
Address: 2107 Nicholas Ave S.E. Wash DC
19. Jan 19- 1945 (Date rec'd by registrar) Howard L Beall Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 18 1945, at 9:00 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Asphyxia	
Due to: Drowning	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 1-18-45
Where did injury occur? Oxon Hill (City or town) Prince Georges (County) Md (State)
Injured at home, farm, industry, public place (where?) Broad Creek
Means of injury: Fell in creek Injured at work? No

23. SIGNATURE: Deputy Medical Examiner Thomas F Murray M.D. or other
Address: Beltsville Md Date signed: 1-19-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

00783

CERTIFICATE OF DEATH

Reg. Dist. No. 240

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH.
County: Prince Georges
City or town: Brandywine (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 mo
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md County: Prince Georges
City or town: Brandywine (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Michael Wilson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Col	single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Apr. 12, 1944

8. AGE: Years | Months: 7 mos. | Days | If less than one day: ..... hrs. ..... min.

9. Birthplace: Brandywine Md (Town, county, and state)

10. Usual occupation

11. Industry or business: Worker

FATHER 12. Name: Edwin Erwin
FATHER 13. Birthplace: S. Carolina

MOTHER 14. Maiden name: Eloise M. Wilson
MOTHER 15. Birthplace: Wash. D.C.

16. Informant: Raymond Wilson
Address: Brandywine, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-17-45 (month) (day) (year)
Cemetery or crematory: Clinton St. Johns Cem.
Location: Clinton, Md.

18. Funeral director: acting Raymond Wilson
Address: Brandywine

19. 1-17-45 (Date rec'd by registrar) 19.... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 16 1945 at 11 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 15 1944 to Jan 16 1945
and that I last saw him alive on Jan 16 1945

Immediate cause of death	DURATION
Pneumonia	1 week
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: John E. Bowers M.D. M. D. or other
Address: Brandywine Md Date signed 1/17/45